US Family Health Plan

Prior Authorization Request Form for

Fortesta **(testosterone 2% topical gel)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 3 **Please complete the clinical assessment:**

1. Is the requested medication being used for female-to-male gender reassignment (endocrinologic masculinization)?	☐ Yes **SKIP to question 5**	☐ No **Proceed to question 2**
2. Is the patient a male who is greater than 17 years of age?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of hypogonadism as evidenced by 2 or more morning total testosterone levels below 300 ng/dL ?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Is the patient experiencing symptoms usually associated with hypogonadism?	☐ Yes **Sign and date on page 2**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a diagnosis of gender dysphoria made by a TRICARE-authorized mental health provider according to most current edition of the DSM?	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**
6. Is the patient 16 years of age or older?	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**
7. Is the patient a biological female of childbearing potential?	☐ Yes **Proceed to question 8**	☐ No **SKIP to question 9**
8. Is the patient pregnant or breastfeeding	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 9**
9. Has the patient experienced puberty to at least Tanner stage 2?	☐ Yes **Proceed to question 10**	☐ No **STOP** **Coverage not approved**

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10. Does the patient have psychiatric comorbidity that would confound a diagnosis of gender dysphoria or interfere with treatment (for example: unresolved body dysmorphic disorder; schizophrenia or other psychotic disorders that have not been stabilized with treatment)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 11**
11. Does the patient have a documented minimum of three months of real-life experience (RLE) and/or three months of continuous psychotherapy addressing gender transition as an intervention for gender dysphoria?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 4

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[10 May 2017]