

USFHP Prior Authorization Request Form for
testosterone undecanoate capsules (**Jatenzo, Kyzatrex, Tlando**)

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 855-273-5735

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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior authorization for initial therapy expires in 1 year. Prior authorization for continuation of therapy for adults does not expire. Clinical documentation may be required.

**Step
1**

Medication requested: ☐ Jatenzo ☐ Kyzatrex ☐ Tlando

**Step
2**

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. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.	☐ Yes Proceed to question 2	☐ No Proceed to question 3
2. Has the patient had a positive response to therapy and do the benefits of continued therapy outweigh the risks?	☐ Yes Sign and date below	☐ No STOP Coverage not approved
3. What is the indication or diagnosis?	☐ Hypogonadism in males - Proceed to question 4 ☐ Female-to-male hormone therapy in a natal female patient (assigned female at birth) - Proceed to question 8 ☐ Other - Proceed to question 15	
4. Is the patient 18 years of age or older?	☐ Yes Proceed to question 5	☐ No STOP Coverage not approved
5. Does the patient have a confirmed diagnosis of hypogonadism as evidenced by morning total serum testosterone levels below 300 ng/dL taken on at least two separate occasions?	☐ Yes Proceed to question 7	☐ No Proceed to question 6

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6. Is the requested medication being prescribed by an endocrinologist or urologist who has made the diagnosis of hypogonadism based on unequivocally and consistently low serum total testosterone or free testosterone levels?	☐ Yes Proceed to question 7	☐ No STOP Coverage not approved
7. Is the patient experiencing signs and symptoms associated with hypogonadism?	☐ Yes Proceed to question 16	☐ No STOP Coverage not approved
8. Is the indication for initiation or continuation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)?	☐ Initiation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)- Proceed to question 9 ☐ Continuation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)- Proceed to question 10	
9. Is the patient a female active duty servicemember?	☐ Yes (Female active duty servicemembers) – STOP - Coverage not approved ☐ No (Female non-active duty servicemembers) - Proceed to question 10	
10. Is the patient 19 years of age or older?	☐ Yes Proceed to question 11	☐ No STOP Coverage not approved
11. Does the patient have a diagnosis of gender dysphoria made by a TRICARE authorized mental health provider according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)?	☐ Yes Proceed to question 12	☐ No STOP Coverage not approved
12. Is the requested medication being prescribed by an endocrinologist or a physician who specializes in the treatment of transgender patients?	☐ Yes Proceed to question 13	☐ No STOP Coverage not approved
13. Is the patient a biological female of childbearing potential and is the patient pregnant or breastfeeding?	☐ Yes STOP Coverage not approved	☐ No Proceed to question 14
14. Does the patient have a 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 16
15. If the indication is not listed above, please write in the requested indication and rationale for use. Note: Enhancing athletic performance alone is not an approved indication.	Proceed to question 16	

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16. Is the patient a male Active Duty Service Member whose testosterone replacement needs are not met with topical gels or standard injectable formulations, requiring an oral capsule formulation?	☐ Yes Sign and date below	☐ No Proceed to question 17
17. Has the patient tried and failed a 3 month trial of one drug from each of the following two categories: (1) testosterone cypionate IM injection or testosterone enanthate IM injection; (2) testosterone 1% gel (for example, generic Androgel, generic Testim, etc.), 1.62% gel (generic Androgel), or 2% solution (generic Axiron)?	☐ Yes Sign and date below	☐ No Proceed to question 18
18. Has the patient experienced a clinically significant adverse reaction, or had a contraindication or relative contraindication to one drug from each of the following two categories: (1) testosterone cypionate IM injection or testosterone enanthate IM injection; (2) testosterone 1% gel (for example, generic Androgel, generic Testim, etc.), 1.62% gel (generic Androgel), or 2% solution (generic Axiron)?	☐ Yes Sign and date below	☐ No STOP Coverage not approved

Step I certify the above is true to the best of my knowledge. Please sign and date:
4

Prescriber Signature

Date

[09 October 2026]