# US Family Health Plan
# Prior Authorization Request Form for
# Androderm, AndroGel, Natesto, Testim, Testosterone 1.62% gel, Vogelxo

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**

**Step 1** **Medication requested:**

**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. Is the requested medication being used for female-to-male gender reassignment (endocrinologic masculinization)?** | ☐ Yes<br>**SKIP to question 7** | ☐ No<br>**Proceed to question 2** |
| **2. Is the patient a male who is greater than 17 years of age?** | ☐ Yes<br>**Proceed to question 3** | ☐ No<br>**STOP**<br>**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<br>**Proceed to question 4** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Has the provider investigated the etiology of the low testosterone levels and acknowledges that testosterone therapy is clinically appropriate and needed?** | ☐ Yes<br>**Proceed to question 5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Is the patient experiencing symptoms usually associated with hypogonadism?** | ☐ Yes<br>**Proceed to question 6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Has the patient tried Fortesta (testosterone 2% gel) or testosterone 1% gel (Androgel 1% generic) for a minimum of 90 days AND failed to achieve total serum testosterone levels above 400 ng/dL (labs drawn 2 hours after Fortesta application) AND without improvement in symptoms?** | ☐ Yes<br>**Sign and date on page 2** | ☐ No<br>**SKIP to question 13** |
| **7. Does the patient have a diagnosis of gender dysphoria made by a USFHP-authorized mental health provider according to most current edition of the DSM?** | ☐ Yes<br>**Proceed to question 8** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **8. Is the patient 16 years of age or older?** | ☐ Yes<br>**Proceed to question 9** | ☐ No<br>**STOP**<br>**Coverage not approved** |

| | | |
|---|---|---|
| **9. Is the patient a biological female of childbearing potential?** | ☐ Yes<br>**Proceed to question 10** | ☐ No<br>**SKIP to question 11** |
| **10. Is the patient pregnant or breastfeeding?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Proceed to question 11** |
| **11. Has the patient experienced puberty to at least Tanner stage 2?** | ☐ Yes<br>**Proceed to question 12** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **12. 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<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Proceed to question 17** |
| **13. Does the patient have a contraindication or relative contraindication to Fortesta or testosterone 1% gel (Androgel 1% generic) that does not apply to the requested agent?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**Proceed to question 14** |
| **14. Has the patient experienced a clinically significant skin reaction to Fortesta or testosterone 1% gel (Androgel 1% generic) that is not expected to occur with the requested agent?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**Proceed to question 15** |
| **15. Is the request for Androderm or Natesto?** | ☐ Yes<br>**Proceed to question 16** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **16. Does the patient require a testosterone replacement therapy that has a low risk of skin-to-skin transfer between family members?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **17. Does the patient have a contraindication or relative contraindication to Fortesta or testosterone 1% gel (Androgel 1% generic) that does not apply to the requested agent?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**Proceed to question 18** |
| **18. Has the patient experienced a clinically significant skin reaction to Fortesta or testosterone 1% gel (Androgel 1% generic) that is not expected to occur with the requested agent?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**Proceed to question 19** |
| **19. Is the request for Androderm or Natesto?** | ☐ Yes<br>**Proceed to question 20** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **20. Does the patient require a testosterone replacement therapy that has a low risk of skin-to-skin transfer between family members?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

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

Prescriber Signature _____ Date _____