US Family Health Plan
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.

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. Will the requested medication be used to enhance athletic performance?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Will the requested medication be used concomitantly with other testosterone products?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. 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 **4**	☐ No Proceed to question **6**
4. Has the patient had a positive response to therapy?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Do the benefits of continued therapy outweigh the risks?	☐ Yes **Sign and date on page 3**	☐ No **STOP** **Coverage not approved**

6. What is the indication or diagnosis?	☐ Hypogonadism - Proceed to question **7** ☐ Female-to-male hormone therapy in a natal female patient - Proceed to question **14** ☐ Other - Proceed to question **23**	
7. Is the patient male?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient 18 years of age or older?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. 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 **11**	☐ No Proceed to question **10**
10. 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 **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient experiencing signs and symptoms associated with hypogonadism?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Has the provider investigated the etiology of the low testosterone levels and has assessed the risks versus benefits of initiating testosterone therapy in this patient?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the provider acknowledge that testosterone therapy is clinically appropriate and needed?	☐ Yes Proceed to question **24**	☐ No **STOP** **Coverage not approved**
14. Is the patient a female active duty servicemember?	☐ Yes (Female active duty servicemembers) – Proceed to question **15** ☐ No (Female non-active duty servicemembers) - Proceed to question **15**	
15. Is the patient 14 years of age or older?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. 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 **17**	☐ No **STOP** **Coverage not approved**
17. Is the requested medication being prescribed by an endocrinologist or a physician who specializes in the treatment of transgender patients?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**

18. Is the patient an adult, or an adolescent with sufficient mental capacity to give informed consent for this partially irreversible treatment?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. Has the patient experienced puberty to at least Tanner stage 2?	☐ Yes Proceed to question **20**	☐ No **STOP** **Coverage not approved**
20. Is the patient of childbearing potential?	☐ Yes Proceed to question **21**	☐ No Proceed to question **22**
21. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **22**
22. 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 **24**
23. If the indication is not listed above, please write in the requested indication and rationale for use.	_____ Proceed to question **24**	
24. 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 **25**
25. 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 4 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date