US Family Health Plan
Prior Authorization Request Form for
Testosterone Cypionate and Testosterone Enanthate IM injections

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**

Prior authorization for initial therapy expires in 1 year. Prior authorization for continuation of therapy does not expire.
Prior authorization is not required for patients less than 1 year of age.

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 2 **Please complete the clinical assessment:**

1. Will the requested medication be used concomitantly with other testosterone products?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for the requested medication.*	☐ Yes (subject to verification) Proceed to question **3**	☐ No Proceed to question **5**
3. Has the patient had a positive response to therapy?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Do the risks of continued therapy outweigh the benefits?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
5. What is the diagnosis or indication?	☐ Hypogonadism - Proceed to question **6** ☐ Female-to-male gender reassignment (endocrinologic masculinization) - Proceed to question **13** ☐ Breast cancer - Proceed to question **21** ☐ Other - **STOP Coverage not approved**	

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6. Was the patient male at birth?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient 18 years of age or older?	☐ Yes Proceed to question **9**	☐ No Proceed to question **8**
8. Is the prescription written by or in consultation with a pediatric endocrinologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. 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 **10**	☐ No **STOP** **Coverage not approved**
10. Has the provider investigated the etiology of the low testosterone levels and acknowledges that testosterone therapy is clinically appropriate and needed?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have prostate cancer?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Is the patient experiencing symptoms usually associated with hypogonadism?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. 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 Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Is the patient an adult?	☐ Yes Proceed to question **17**	☐ No Proceed to question **15**
15. Is the patient greater than or equal to 16 years of age?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Has the patient experienced puberty to at least Tanner stage 2?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**

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17. Does the patient have signs of breast cancer?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **18**
18. Is the patient a biological female of childbearing potential?	☐ Yes Proceed to question **19**	☐ No Proceed to question **20**
19. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **20**
20. 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 **Sign and date below**
21. Is the patient female?	☐ Yes Proceed to question **22**	☐ No **STOP** **Coverage not approved**
22. Is the prescription written by or in consultation with an oncologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[5 April 2023]