

**USFHP Prior Authorization Request Form for  
Testosterone cypionate IM, testosterone enanthate IM,  
testosterone enanthate (Xyosted)**

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 is not required for patients younger than 1 year of age.***

Prior authorization for initial therapy expires in 1 year. Prior authorization for continuation of therapy for adults does not expire. Prior authorization for continuation of therapy for children expires in 1 year.

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

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

**Step 2 Please complete the clinical assessment:**

<b>2</b>	1. Will the requested medication be used to enhance athletic performance?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 2
	2. Will the requested medication be used concomitantly with other testosterone products?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes (subject to verification) Proceed to question 4	<input type="checkbox"/> No Proceed to question 8
	4. What is the indication or diagnosis?	<input type="checkbox"/> Hypogonadism - Proceed to question 6 <input type="checkbox"/> Female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth) - Proceed to question 5 <input type="checkbox"/> Breast cancer - Proceed to question 6 <input type="checkbox"/> Other - Proceed to question 6	
	5. Is the patient 19 years of age or older?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No <b>STOP</b>

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		<b>Coverage not approved</b>
<b>6. Has the patient had a positive response to therapy?</b>	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
<b>7. Do the benefits of continued therapy outweigh the risks?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
<b>8. What is the indication or diagnosis?</b>	<input type="checkbox"/> Hypogonadism - Proceed to question 9 <input type="checkbox"/> Female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth) - Proceed to question 17 <input type="checkbox"/> Breast cancer - Proceed to question 25 <input type="checkbox"/> Other - Proceed to question 26	
<b>9. Is the patient a male who is 18 years of age or older?</b>	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No Proceed to question 10
<b>10. What is the requested medication?</b>	<input type="checkbox"/> Testosterone cypionate IM- Proceed to question 11 <input type="checkbox"/> Testosterone enanthate IM- Proceed to question 11 <input type="checkbox"/> Xyosted – <b>STOP Coverage not approved</b>	
<b>11. 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?</b>	<input type="checkbox"/> Yes Proceed to question 13	<input type="checkbox"/> No Proceed to question 12
<b>12. Is testosterone 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?</b>	<input type="checkbox"/> Yes Proceed to question 13	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
<b>13. Is the patient experiencing signs and symptoms associated with hypogonadism?</b>	<input type="checkbox"/> Yes Proceed to question 14	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
<b>14. Has the provider investigated the etiology of the low testosterone levels?</b>	<input type="checkbox"/> Yes Proceed to question 15	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
<b>15. Has the provider assessed the risks versus benefits of initiating testosterone therapy in this patient?</b>	<input type="checkbox"/> Yes Proceed to question 16	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
<b>16. Does the provider acknowledge that testosterone therapy is clinically appropriate and needed?</b>	<input type="checkbox"/> Yes Proceed to question 27	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>

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<p><b>17. Is the indication for initiation or continuation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)?</b></p>	<p><input type="checkbox"/> Initiation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)- Proceed to question <b>18</b></p> <p><input type="checkbox"/> Continuation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)- Proceed to question <b>19</b></p>	
<p><b>18. Is the patient a female active duty servicemember?</b></p>	<p><input type="checkbox"/> Yes (Female active duty servicemembers) – <b>STOP - Coverage not approved</b></p> <p><input type="checkbox"/> No (Female non-active duty servicemembers) - Proceed to question <b>19</b></p>	
<p><b>19. Is the patient 19 years of age or older?</b></p>	<p><input type="checkbox"/> Yes Proceed to question <b>20</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>20. 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 DSM?</b></p>	<p><input type="checkbox"/> Yes Proceed to question <b>21</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>21. Is the requested medication being prescribed by an endocrinologist or a physician who specializes in the treatment of transgender patients?</b></p>	<p><input type="checkbox"/> Yes Proceed to question <b>22</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>22. Is the patient a biological female of childbearing potential?</b></p>	<p><input type="checkbox"/> Yes Proceed to question <b>23</b></p>	<p><input type="checkbox"/> No Proceed to question <b>24</b></p>
<p><b>23. Is the patient pregnant or breastfeeding?</b></p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question <b>24</b></p>
<p><b>24. 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)?</b></p>	<p><input type="checkbox"/> Yes <b>STOP</b> Coverage not approved</p>	<p><input type="checkbox"/> No Proceed to question <b>27</b></p>
<p><b>25. Is the prescription written by or in consultation with an oncologist?</b></p>	<p><input type="checkbox"/> Yes Proceed to question <b>27</b></p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>26. Document the requested indication and rationale for use.</b></p>	<div style="border: 1px solid black; height: 100px; width: 100%;"></div> <p style="text-align: right;">Proceed to question <b>27</b></p>	

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<b>27. What is the requested medication?</b>	<input type="checkbox"/> Testosterone cypionate IM - <b>Sign and date below</b> <input type="checkbox"/> Testosterone enanthate IM - <b>Sign and date below</b> <input type="checkbox"/> Xyosted - <b>Proceed to question 28</b>	
<b>28. 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), 1.62% gel (generic Androgel), or 2% solution (generic Axiron)?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>Proceed to question 29</b>
<b>29. Has the patient experienced a clinically significant adverse reaction 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), 1.62% gel (generic Androgel), or 2% solution (generic Axiron)?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>Proceed to question 30</b>
<b>30. Has the patient 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), 1.62% gel (generic Androgel), or 2% solution (generic Axiron)?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>

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

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

[16 July 2025]