INDIANA HEALTH COVERAGE PROGRAMS (IHCP) TESTOSTERONES PRIOR AUTHORIZATION REQUEST FORM



MDwise Fax to: (858) 790-7100 c/o MedImpact Healthcare Systems, Inc. Attn: Prior Authorization Department 10181 Scripps Gateway Court, San Diego, CA 92131 Phone: (800) 788-2949



Today's Date				
Note: This form must be completed by the prescribing provider.				
	must be complete	ed or the request	will be returned**	
Patient's Medicaid #	Patient's Medicaid # Date of Birth / / / / /			
Patient's Name Prescriber's Name				
Prescriber's IN License # Specialty				
Prescriber's NPI#	Prescriber's NPI# Prescriber's Signature			
Return Fax #	Return Fax # Return Phone #			
Check box if requesting retro-active PA	Check box if requesting retro-active PA Date(s) of service requested for retro-active eligibility (if applicable):			
Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).				
Requested Medication	Strength	Quantity	Dosage Regimen	
DEPO-TESTOSTERONE, TESTOST Initial Authorization: 1. Please select one of the following: ☐ Member has a diagnosis of do ☐ Member has a total testostero 2. For ALL indications: Provider attests that member has ■ Breast cancer in a memb ■ Pregnancy ■ Prostate cancer	elayed puberty one level ≤ 350 ng/ none of the follow	dL within the past ring contraindicatio	3 months (Documentation is required) ons to therapy: □ Yes □ No	
If no, please specify contrained				

Reauthorization: 1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) □ Yes □ No
2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
TESTOSTERONE ENANTHATE
Initial Authorization: 1. Please select one of the following:
☐ Member has a diagnosis of delayed puberty
Has the member had a previous trial and failure of ALL preferred injectable testosterone agents
(reference PA criteria)? ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
 Member has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) Has the member had a previous trial and failure of ALL preferred injectable testosterone agents (reference PA criteria)?
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
☐ Member needs medication for palliative treatment of metastatic breast cancer 2. For ALL indications:
Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No ■ Breast cancer in a member assigned male at birth ■ Pregnancy ■ Prostate cancer
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
Reauthorization:
1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Has the member had a previous trial and failure of at least ONE preferred injectable testosterone agent (not required for palliative treatment of breast cancer) [reference PA criteria]? ☐ Yes ☐ No

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If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
3. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
AVEED, TESTOPEL PELLET, XYSOTED
Initial Authorization:
Please select one of the following:
☐ Member has a diagnosis of delayed puberty
 Has the member had a previous trial and failure of ALL preferred injectable testosterone agents (reference PA criteria)? ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
 Member has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) Has the member had a previous trial and failure of ALL preferred injectable testosterone agents (reference PA criteria)? ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No
Breast cancer in a member assigned male at birth
 Hypogonadal conditions not associated with structural or genetic etiologies (Xyosted ONLY) Pregnancy
Prostate cancer
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
Reauthorization:
1. Total testosterone level is ≤1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Has the member had a previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria)? ☐ Yes ☐ No

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3. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above	If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
the contraindication(s) listed under initial authorization above □ Yes □ No If no, please specify contraindication and medical rationale for use: □ Prescriber Signature: □ TESTOSTERONE 1% (25 Mg)/2.5 GM GEL PACKETS, TESTOSTERONE 1% (12.5 Mg)/ACT GEL PUMP, TESTOSTERONE 1.62% (20.25 Mg)/ACT METERED PUMP GEL, TESTIM 1% (50 MG)/5 GM GEL PACKETS Initial Authorization: 1. Please select one of the following: □ Member is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required), and is requesting to use topical testosterone within the established quantity limits Requested dose: □ Member is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical testosterone therapy (Documentation is required) and is requesting to exceed established quantity limits Requested dose: □ Member has utilized ≥ 14 days of topical testosterone therapy: □ Yes □ No Name of medication: □ Dose: □ Start and End date: □ If no, please provide medical justification as to why member is requesting a dose beyond established quantity limits: 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: □ Yes □ No • Breast cancer in a member assigned male at birth • Pregnancy • Prostate cancer	
TESTOSTERONE 1% (25 MG)/ 2.5 GM GEL PACKETS, TESTOSTERONE 1% (12.5 MG)/ACT GEL PUMP, TESTOSTERONE 1.62% (20.25 MG)/ACT METERED PUMP GEL, TESTIM 1% (50 MG)/5 GM GEL PACKETS Initial Authorization: 1. Please select one of the following: Member is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required), and is requesting to use topical testosterone within the established quantity limits Requested dose:	
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Initial Authorization: 1. Please select one of the following: Member is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required), and is requesting to use topical testosterone within the established quantity limits Requested dose:	TEST COTED ONE 407 (SE MOVIA E ON CEL DA OVETO TEST COTED ONE 407 (ASE MOVIA OT CEL DUMP
1. Please select one of the following:	
Member is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical testosterone therapy (Documentation is required) and is requesting to exceed established quantity limits Requested dose: Member has utilized ≥ 14 days of topical testosterone therapy: □ Yes □ No Name of medication: Dose: Start and End date: If no, please provide medical justification as to why member is requesting a dose beyond established quantity limits: 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: □ Yes □ No • Breast cancer in a member assigned male at birth • Prostate cancer	 Please select one of the following: Member is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required), and is requesting to use topical testosterone within the established quantity
testosterone therapy (Documentation is required) and is requesting to exceed established quantity limits Requested dose: Member has utilized ≥ 14 days of topical testosterone therapy: □ Yes □ No Name of medication: □ Dose: □ Start and End date: □ If no, please provide medical justification as to why member is requesting a dose beyond established quantity limits: □ 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: □ Yes □ No ■ Breast cancer in a member assigned male at birth ● Pregnancy ● Prostate cancer	Requested dose:
Member has utilized ≥ 14 days of topical testosterone therapy: ☐ Yes ☐ No Name of medication: ☐ ☐ Dose: ☐ ☐ Start and End date: ☐ ☐ If no, please provide medical justification as to why member is requesting a dose beyond established quantity limits: ☐ ☐ 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No ■ Breast cancer in a member assigned male at birth ■ Pregnancy ■ Prostate cancer	
Name of medication: Dose: Start and End date: If no, please provide medical justification as to why member is requesting a dose beyond established quantity limits: 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: Pregnancy Prostate cancer	Requested dose:
Dose: Start and End date: If no, please provide medical justification as to why member is requesting a dose beyond established quantity limits: 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: □ Yes □ No • Breast cancer in a member assigned male at birth • Pregnancy • Prostate cancer	Member has utilized ≥ 14 days of topical testosterone therapy: ☐ Yes ☐ No
Start and End date: If no, please provide medical justification as to why member is requesting a dose beyond established quantity limits: 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: • Breast cancer in a member assigned male at birth • Pregnancy • Prostate cancer	Name of medication:
If no , please provide medical justification as to why member is requesting a dose beyond established quantity limits: 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: • Breast cancer in a member assigned male at birth • Pregnancy • Prostate cancer	Dose:
quantity limits: 2. For ALL indications: Provider attests that member has none of the following contraindications to therapy: □ Yes □ No • Breast cancer in a member assigned male at birth • Pregnancy • Prostate cancer	Start and End date:
Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No ■ Breast cancer in a member assigned male at birth ■ Pregnancy ■ Prostate cancer	
Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No ■ Breast cancer in a member assigned male at birth ■ Pregnancy ■ Prostate cancer	
If no , please specify contraindication and medical rationale for use:	Provider attests that member has none of the following contraindications to therapy: Pregnancy Provider attests that member has none of the following contraindications to therapy: Yes No Pregnancy
	If no , please specify contraindication and medical rationale for use:
Prescriber Signature:	Prescriber Signature:

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Reauthorization:
1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
Dragovikov Cignoturo
Prescriber Signature:
NATESTO, TESTOSTERONE 1% (12.5 MG)/ACT GEL PUMP, TESTOSTERONE 1.62% (40.5 MG)/2.5 GM
GEL PACKETS, TESTOSTERONE 1.62% (20.25 MG)/1.25 GM GEL PACKETS, TESTOSTERONE 2% (10 MG)/ACT METERED PUMP, TESTOSTERONE 30 MG/ACT SOLUTION, VOGELXO 1% (50 MG)/5 GM GEL
PACKETS, VOGELXO 1% (12.5 MG)/ACT GEL PUMP
Initial Authorization: 1. Please select one of the following:
 ☐ Member is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past 3 months
(Documentation is required), and is requesting to use topical testosterone within the established quantity
limits
Requested dose:
testosterone therapy (Documentation is required) and is requesting to exceed established quantity limits
Requested dose:
Member has utilized ≥ 14 days of topical testosterone therapy: ☐ Yes ☐ No
Name of medication:
Dose:
Start and End date:
If no , please provide medical justification as to why member is requesting a dose beyond established quantity limits:
2. Previous trial and failure of ALL preferred topical testosterone agents (reference PA criteria) ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred topical testosterone agents:
O. For All Lindications.
3. For ALL indications: Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No
 Breast cancer in a member assigned male at birth
Pregnancy

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Prostate cancer
If no, please specify contraindication and medical rationale for use:
Prescriber Signature:
Reauthorization: 1. Total testosterone level is ≤1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Previous trial and failure of at least ONE preferred topical testosterone agent ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred topical testosterone agents:
3. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no, please specify contraindication and medical rationale for use:
Prescriber Signature:
DANOCRINE (DANAZOL):
Initial Authorization (approval up to 6 months):
1. Member diagnosis(es):
Note: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia
2. For ALL indications:
Provider attests that member has none of the following contraindications to therapy: Yes No
 Active or history of thrombosis or thromboembolic disease Androgen-dependent tumor
Cardiac disease
Porphyria Province of the action is a second for a circumstance of the action is
 Pregnancy or breast-feeding Severe hepatic disease
Severe renal disease
Undiagnosed genital bleeding
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:

Reauthorization (approval up to 6 months):
Documentation from prescriber indicating continued benefit from the medication without significant adverse events □ Yes □ No
2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
JATENZO (TESTOSTERONE UNDECANOATE):
Initial Authorization: 1. Member is 18 years of age or older □ Yes □ No
2. Member has a diagnosis of hypogonadism with a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) ☐ Yes ☐ No
3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria) ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
4. For ALL indications: Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No ■ Breast cancer in a member assigned male at birth ■ Hypogonadal conditions not associated with structural or genetic etiologies ■ Pregnancy ■ Prostate cancer
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
Reauthorization: 1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of
the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria)

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☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
KYZATREX (TESTOSTERONE UNDECANOATE):
Initial Authorization: 1. Member is 18 years of age or older □ Yes □ No
2. Member has a diagnosis of hypogonadism and a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) ☐ Yes ☐ No
3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria) ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
 4. For ALL indications: Provider attests that member has none of the following contraindications to therapy: Yes No Breast cancer Hypogonadal conditions not associated with structural or genetic etiologies Pregnancy Prostate cancer
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
Reauthorization:
1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
 Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria) ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:

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METHITEST (METHYLTESTOSTERONE)
Initial Authorization (approval up to 6 months):
miliai Addionization (approval up to o months).
 1. Please select one of the following: Member has a diagnosis of cryptorchidism Member has a diagnosis of delayed puberty Member has a diagnosis of hypogonadism (primary or hypogonadotropic) with a total testosterone ≤ 350 ng/dL within the past 3 months (Documentation is required) Member needs medication for palliative treatment of metastatic breast cancer
 Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria) ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
3. For ALL indications:
 Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No Breast cancer in a member assigned male at birth Pregnancy Prostate cancer
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
Reauthorization (approval up to 6 months):
1. Please select one of the following:
☐ Member has a diagnosis of hypogonadism and a total testosterone level ≤ 1000 ng/dL within the past 6
months (Documentation is required)
Member has a diagnosis of delayed puberty, palliative treatment of metastatic breast cancer, or cryptorchidism AND prescriber has submitted documentation indicating continued benefit from the medication without significant adverse events:
2. For ALL indications:
Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria) \square Yes \square No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:

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OXANDRIN (OXANDROLONE):
Initial Authorization (approval up to 6 months):
1. Member diagnosis(es):
Note: Approvable diagnoses include adjunct treatment of severe burns during the catabolic and rehabilitative phases, AIDS-associated wasting syndrome, alcoholic hepatitis, cachexia
2. For ALL indications:
Provider attests that member has none of the following contraindications to therapy: \Box Yes \Box No
 Breast cancer Hypercalcemia Pregnancy Prostate cancer Severe renal disease
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
Reauthorization (approval up to 6 months):
Documentation from prescriber indicating continued benefit from the medication without significant adverse events ☐ Yes ☐ No
2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
TLANDO (TESTOSTERONE UNDECANOATE) Initial Authorization:
1. Member is 18 years of age or older ☐ Yes ☐ No
2. Member has a diagnosis of hypogonadism and a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required) ☐ Yes ☐ No
3. Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria) ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:
 4. For ALL indications: Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No ■ Breast cancer

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 Hypogonadal conditions not associated with structural or genetic etiologies
 Pregnancy
Prostate cancer
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
Reauthorization:
1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) ☐ Yes ☐ No
2. Prescriber attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above \square Yes \square No
of the contramdication(s) listed drider initial authorization above res No
If no , please specify contraindication and medical rationale for use:
Prescriber Signature:
2. Described and failure of at least ONE conformed injectable testactories a work (reference DA criteria)
 Previous trial and failure of at least ONE preferred injectable testosterone agent (reference PA criteria) ☐ Yes ☐ No
If no , please provide medical justification for use of requested agent over ALL preferred injectable testosterone agents:

CONFIDENTIAL INFORMATION

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