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

Note: This form must be completed by the prescribing provider.

**All sections must be completed or the request will be returned**

<table>
<thead>
<tr>
<th>Patient's Medicaid #</th>
<th>Date of Birth</th>
<th>Patient's Name</th>
<th>Prescriber's Name</th>
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<tbody>
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<thead>
<tr>
<th>Prescriber’s IN License #</th>
<th>Specialty</th>
<th>Prescriber’s NPI #</th>
<th>Prescriber’s Signature</th>
</tr>
</thead>
<tbody>
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<tr>
<th>Return Fax #</th>
<th>Return Phone #</th>
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</table>

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).

<table>
<thead>
<tr>
<th>Requested Medication</th>
<th>Strength</th>
<th>Quantity</th>
<th>Dosage Regimen</th>
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DEPO-TESTOSTERONE, TESTOSTERONE CYPIONATE

Initial Authorization:
1. Please select one of the following:
   - [ ] Member has a diagnosis of delayed puberty
   - [ ] Member has a total testosterone level ≤ 350 ng/dL within the past 3 months (Documentation is required)

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:

________________________________________________________________________________

________________________________________________________________________________

Reauthorization:
1. Total testosterone level is ≤ 1000 ng/dL within the past 6 months (Documentation is required) [ ] Yes  [ ] No

01.01.2024
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 □ Yes □ No

   If no, please specify contraindication and medical rationale for use:
   _______________________________________________________________________
   _______________________________________________________________________

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)? □ Yes □ No

   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:
   _______________________________________________________________________
   _______________________________________________________________________

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

   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 □ Yes □ No
If no, please specify contraindication and medical rationale for use:
________________________________________________________________________________
________________________________________________________________________________

AVEED, TESTOPEL PELLET, XYSOTED

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)? □ 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:
________________________________________________________________________________
________________________________________________________________________________

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
   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 □ Yes □ No
   If no, please specify contraindication and medical rationale for use:
________________________________________________________________________________
ANDRODERM, 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 TUBES

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

   If no, please specify contraindication and medical rationale for use:
   __________________________________________________________________________
   __________________________________________________________________________

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 □ Yes □ No

   If no, please specify contraindication and medical rationale for use:
   __________________________________________________________________________
   __________________________________________________________________________

Note: dose requested for reauthorization should not exceed established quantity limits unless member historically has been approved to exceed the established quantity limits

Requested dose: ____________________________________________________________
NATESTO, TESTOSTERONE 1% (50 MG)/5 GM GEL PACKETS/TUBES, 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: __________________________________________________________

   - □ 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. 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:

   __________________________________________________________________________

   __________________________________________________________________________

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:

   __________________________________________________________________________

   __________________________________________________________________________

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 □ Yes □ No

If no, please specify contraindication and medical rationale for use:
________________________________________________________________________________
________________________________________________________________________________

Note: dose requested for reauthorization should not exceed established quantity limits unless member historically has been approved to exceed the established quantity limits

Requested dose:_______________________________________________

DANOCRINE (DANAZOL):

Initial Authorization (approval up to 6 months):
1. Member diagnosis(es):________________________________________________________

Note: Approvable diagnoses include angioedema prophylaxis for hereditary 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
   • Pregnancy or breast-feeding
   • Severe hepatic disease
   • Severe renal disease
   • Undiagnosed genital bleeding

   If no, please specify contraindication and medical rationale for use:
________________________________________________________________________________
________________________________________________________________________________

Reauthorization (approval up to 6 months):

1. 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 □ Yes □ No

   If no, please specify contraindication and medical rationale for use:
________________________________________________________________________________
________________________________________________________________________________
JATENZO (TESTOSTERONE UNDECANOATE):

Initial Authorization:
1. Member is 18 years of age or older and is requesting to use oral testosterone within the established quantity limits
   Requested dose:_______________________________ □ 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:
   ______________________________________________________________________________________
   ______________________________________________________________________________________

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 □ Yes □ No
   If no, please specify contraindication and medical rationale for use:
   ______________________________________________________________________________________
   ______________________________________________________________________________________

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:
   ______________________________________________________________________________________
   ______________________________________________________________________________________

Note: dose requested for reauthorization should not exceed established quantity limits
   Requested dose:___________________________________________________________
METHITEST (METHYLTESTOSTERONE)

Initial Authorization (approval up to 6 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 hypogonadotrophic) 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

2. 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:
   __________________________________________________________________________________
   __________________________________________________________________________________

4. Dose requested of methyltestosterone is within the established quantity limits
   Requested dose:__________________________________________________________ □ Yes □ No

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 □ Yes □ No

   If no, please specify contraindication and medical rationale for use:
   __________________________________________________________________________________
   __________________________________________________________________________________

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:
   __________________________________________________________________________________
Note: dose requested for reauthorization should not exceed established quantity limits

Requested dose:

TLANDO (TESTOSTERONE UNDECANOATE)

Initial Authorization:
1. Member is 18 years of age or older and is requesting to use oral testosterone within the established quantity limits

Requested dose: □ 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:

   __________________________________________________________
   __________________________________________________________

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 □ Yes □ No

   If no, please specify contraindication and medical rationale for use:

   __________________________________________________________
   __________________________________________________________

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:

   __________________________________________________________
   __________________________________________________________

Note: dose requested for reauthorization should not exceed established quantity limits