UnitedHealthcare Community Plan

Androgenic Agents
Testosterone Replacement Therapy (TRT) - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

□ Yes □ No	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Primary Hypogonadism (congenital or acquired) □ Hypogonadotropic Hypogonadism (congenital or acquired) □ HIV-associated weight loss (Testosterone Replacement Therapy for Adult Males) □ Chronic, high-dose glucocorticoid-therapy (Testosterone Replacement Therapy for Adult Males) □ Men with osteoporosis or young men with low trauma fractures (Testosterone Replacement Therapy for Adult Males) □ Delayed puberty that is NOT secondary to a pathological cause □ Advancing, inoperable metastatic breast cancer □ Gender dysphoria (Transgender health, patient identifies as female-to-male)
□ Yes □ No	**Has the patient demonstrated failure or intolerance to any of the preferred Androgenic - Testosterone Agents?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the patient had TWO morning (between 8 a.m. to 10 a.m.) tests (at least 1 week apart) at baseline demonstrating low testosterone levels? (NOTE: Low testosterone is defined as Total serum testosterone level less than 300ng/dL (10.4nmol/L) OR Total serum testosterone level less than 350ng/dL (12.1nmol/L) AND free serum testosterone level less than 50pg/mL (or 0.174nmol/L)).** *List 1st testosterone level / time and date of draw:* *List 2nd testosterone level / time and date of draw:*
	Is the patient male or female? *(Check which applies)* □ Male □ Female
□ Yes □ No	**Does the patient have any of the following contraindications?** *(If yes, check which applies)* □ Breast cancer or known or suspected prostate cancer □ Elevated hematocrit (>50%) □ Untreated severe obstructive sleep apnea □ Severe lower urinary tract symptoms □ Uncontrolled or poorly-controlled heart failure □ Major cardiovascular event (such as a myocardial infraction, stroke, acute coronary syndrome) in the past six months □ Uncontrolled or poorly-controlled benign prostate hyperplasia or is at a higher risk of prostate cancer, such as elevation of PSA after initiating TRT (Testosterone Replacement Therapy)

PRIMARY HYPOGONADISM

□ Yes □ No	**Does the patient have testicular failure due to one of the following conditions?** *(If yes, check which applies)* □ Cryptorchidism □ Orchidectomy □ Vanishing testis syndrome □ Bilateral torsion □ Klinefelter's syndrome □ Trauma □ Orchitis □ Chemotherapy □ Toxic damage from alcohol or heavy metals

HYPOGONADOTROPIC HYPOGONADISM

□ Yes □ No	**Does the patient have idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency, or pituitary-hypothalamic injury from tumors, trauma or radiation?** *If yes, list what applies:*

HIV- ASSOCIATED WEIGHT LOSS

□ Yes □ No	**Does the patient meet either of the following?** *(If yes, check which applies)* □ <90% of ideal body weight, List percentage of ideal body weight: _____ □ Weight loss of >10% in the last 6 months, List percentage of weight loss in last 6 months: _____

CHRONIC, HIGH-DOSE GLUCOCORTICOID-THERAPY

□ Yes □ No	**Has the patient had more than 5mg/day of prednisone, or equivalent daily, for greater than two (2) weeks?** *(If yes, complete Section D above)*

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	DELAYED PUBERTY
□ **Yes** □ **No**	**Is there documentation of family history to demonstrate familial delayed puberty?** *If yes, list supporting documentation:*
□ **Yes** □ **No**	**Has the provider obtained random measurements of serum LH, FSH, and testosterone?** *If yes, list serum LH / FSH / testosterone / dates collected:*
□ **Yes** □ **No**	**Has the patient tried and failed "watchful waiting" with reassurance and psychological support?**
	METASTATIC BREAST CANCER
□ **Yes** □ **No**	**Is testosterone treatment considered secondarily to failure of first-line therapies?** *If yes, list first-line therapies:*
□ **Yes** □ **No**	**Does the patient meet either of the following?** *(If yes, check which applies)* □ Patient is 1 to 5 years postmenopausal □ Patient is premenopausal and has demonstrated benefit from oophorectomy and has a hormone-responsive tumor
□ **Yes** □ **No**	**Is the requested medication prescribed by an oncologist with expertise in the field?** *If yes, list expertise:*
	TRANSGENDER HEALTH, FEMALE-TO-MALE
□ **Yes** □ **No**	**Has the patient's diagnosis of gender dysphoria been defined by both of the following?** *(If yes, check which applies)* □ Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria by a licensed behavioral health practitioner □ One of the following: Licensed behavioral health practitioner OR Licensed physician, advanced registered nurse practitioner (ARNP), physician's assistant (PA), or psychologist who is treating the patient for primary care or transgender services who is continuing to treat the patient with a comprehensive patient-centered treatment plan
□ **Yes** □ **No**	**Is the diagnosis of gender dysphoria due to another mental or physical health condition?**
□ **Yes** □ **No**	**Does the provider have documentation that the patient has the capacity to make fully informed decisions and consents for the treatment of gender dysphoria?** *If yes, list documentation:*
□ **Yes** □ **No**	**Does the prescriber meet all of the following?** *(If yes, check which applies)* □ Meet the requirements of professional licensure and practice according to the scope of practice for their license □ Demonstrate specialized competencies in managing hormone therapies for gender dysphoria (including documentation of supervised training or mentoring by a more experienced physician) □ Follow the standards of care for the health of transgender, transsexual and gender-nonconforming people outlined by the World Professional Association for Transgender Health (WPATH)
	CONTINUATION OF THERAPY
□ **Yes** □ **No**	**Does the patient have documented positive clinical response to therapy?** *If yes, list positive response:*

Provider Signature: _____ **Date:** _____