aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-296-0323 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/newjersey/providers/pharmacy

Testosterone Agents
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information							
Preferred Agents:	☐ **Testosterone enanthate**	☐ **Testosterone cypionate**	☐ **Testosterone packets**	☐ **Testosterone gel**			
Non-Preferred Agents:	☐ Androderm	☐ Testopel	☐ Delatestryl	☐ Vogelxo	☐ Androgel	☐ Aveed	☐ Axiron
	☐ Striant	☐ Testim	☐ Depo-Testosterone	☐ Fortesta	☐ Natesto		
	☐ Other, please specify:						

Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No	ICD-10 Code:	Diagnosis:
What medication(s) have been tried and failed for the diagnosis?		

Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information			
☐ **Testosterone Replacement Therapy**			
Are there 2 pre-treatment serum total testosterone levels confirmed on 2 separate mornings with results below the normal range (<264ng/dL or less than reference range for lab)?	☐ Yes	☐ No	☐ N/A
Is there 1 pretreatment free or bioavailable testosterone level (less than reference range for lab)?	☐ Yes	☐ No	☐ N/A
Does member have a condition that may alter sex-hormone binding globulin (for example obesity, diabetes mellitus, hypothyroidism, etc.)?	☐ Yes	☐ No	☐ N/A
Are member's initial testosterone concentrations at or near the lower limit of normal?	☐ Yes	☐ No	☐ N/A

Does member have ONE of the following diagnosis?	☐ Bilateral Orchiectomy	☐ Genetic disorder due to hypogonadism (for example, Klinefelter syndrome)	☐ Panhypopituitarism

Was diagnosis of hypogonadism made during or recovery from an acute illness, or when member was engaged in short-term use of certain medications (for example opioids or glucocorticoids)?	☐ Yes	☐ No
Does member have a diagnosis of Prostate Cancer OR Male Breast Cancer?	☐ Yes	☐ No

Provider will be monitoring the following periodically	☐ Serum	☐ Prostate	☐ Hemoglobin	☐ Liver functions

(check all that apply):	testosterone	specific antigen	& hematocrit	tests	
☐ **Renewal Request Only**					
Is testosterone within normal male range?	☐ Yes	☐ No	Is hematocrit < 54%?	☐ Yes	☐ No
The following labs are being monitored (check all that apply):	☐ PSA	☐ Hemoglobin	☐ LFTs		
Has member developed prostate cancer OR male breast cancer?				☐ Yes	☐ No
☐ **Female to Male Transsexualism**					
Was there an evaluation from mental health professional showing persistent, well-documented diagnosis of gender dysphoria?	☐ Yes	☐ No	Was informed consent obtained from member?	☐ Yes	☐ No
Have co-morbid mental health concerns been OR are actively being addressed?				☐ Yes	☐ No
☐ **Renewal Request Only**					
Is testosterone within normal male range?	☐ Yes	☐ No	Is hematocrit < 54%?	☐ Yes	☐ No
☐ **Delayed Puberty**					
Have serial physical evaluations been made over time (6 months or more) to help confirm diagnosis?				☐ Yes	☐ No
Examinations include measurements of the following (check that apply):	☐ Height-Weight	☐ Tanner stage of pubertal development	☐ Bone Age	☐ Testicular Size	
Are there few to no signs of puberty?	☐ Yes	☐ No	Is pubertal delay severe?	☐ Yes	☐ No
Are member's psychosocial concerns able to be resolved without treatment?				☐ Yes	☐ No
☐ **Renewal Request Only**					
Measurements of the following continue to be taken (check that apply):	☐ Height-Weight	☐ Tanner stage of pubertal development	☐ Bone Age	☐ Testicular Size	
Is there still evidence of small testes?	☐ Yes	☐ No	Is hematocrit <54%?	☐ Yes	☐ No
☐ **Palliative Treatment of Inoperable Breast Cancer in Women**					
Is requested medication prescribed by oncologist?				☐ Yes	☐ No
☐ **Renewal Request Only**				☐ Yes	☐ No
Is member responding to therapy without disease progression?				☐ Yes	☐ No
☐ **Acquired Immuno-Deficiency Syndrome - Associated Wasting Syndrome**					
Has member been diagnosed with HIV-AIDS?	☐ Yes	☐ No	Has member lost at least 10% body weight?	☐ Yes	☐ No
☐ **Renewal Request Only**					
Has member seen and maintained an increase in weight from baseline?	☐ Yes	☐ No	Is hematocrit <54%?	☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.					

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 855-232-3596 to check the status of a request.