AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Testosterone Replacement Therapy (Injectable)
(MUST be purchased by Physician's Office)

Drug Requested: (Check box below that applies)

NON-PREFERRED	
❑ **Aveed®** (testosterone undecanoate IM injection) **(J3145)**	❑ **Testopel®** (testosterone pellets) **(11980/S0189)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Maximum Dosage:

- Testopel - 75mg implantable pellet; 6 pellets per 90 day supply (6 billable units every 90 days)
- Aveed - 3 mL (750 mg) injected intramuscularly, followed by 3 mL (750 mg) injected after 4 weeks, then 3 mL (750 mg) injected every 10 weeks

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❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Member has Partial Androgen Insensitivity Syndrome with male gender identity/gender dysphoria or delayed male puberty

OR

❑ Member has hypogonadism confirmed by low testosterone levels:

- ❑ **TWO (2) MORNING (6AM to 11AM)** testosterone levels **obtained on different dates** that are below 300 ng/dL or below the lower limit of normal for the reference range **(attach lab results with reference ranges from the laboratory for both)**
  - ❑ First testosterone level: _____
  - ❑ Repeat testosterone or free testosterone level: _____

AND

❑ Member has at least one specific symptom and at least two non-specific symptoms:

Specific Symptoms (≥1 of the following)	**Non-Specific Symptoms** (≥2 of the following)
❑ Incomplete or delayed sexual development	❑ Decreased energy, motivation, initiative and self-confidence
❑ Reduced sexual desire (libido) and activity	❑ Depressed mood
❑ Decreased spontaneous erections*	❑ Poor concentration and memory
❑ Breast discomfort, gynecomastia	❑ Sleep disturbances, increased sleepiness
❑ Loss of body hair (axillary, facial, and/or pubic)	❑ Mild anemia (Hgb 10-11 gm/dL)
❑ Small testes (<5 mL) or shrinking testes	❑ Reduced muscle bulk and strength due to cachexia
❑ Low or zero sperm count	❑ Increased body fat, BMI
❑ Height loss, low trauma fracture or low bone mineral density	❑ Diminished physical or work performance
❑ Hot flushes, sweats	

***If 'decreased spontaneous erections' is the ONLY symptom documented in chart notes, the request will be denied as testosterone replacement is EXCLUDED from coverage for sexual dysfunction.**

AND

❑ Member has had an inadequate response, contraindication or intolerance to at least a three month trial with a topical agent e.g., testosterone gel, testosterone patch, testosterone topical solution, testosterone nasal gel **(verified by pharmacy paid claims)**

_____ **(Please document date/name of drug)**

AND

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- ❑ Member has had an inadequate response, contraindication or intolerance to at least a three month trial of a preferred intramuscular testosterone medication e.g., testosterone cypionate, testosterone enanthate or testosterone undecanoate **(verified by pharmacy paid claims)**

  _____ **(Please document date/name of drug)**

Note: For the hypogonadism indication, testosterone drugs CANNOT be used in conjunction with other erectile dysfunction drugs.

Medication being provided by (check box below that applies)**:**

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by the Pharmacy and Therapeutics Committee**: 3/19/2014
REVISED/UPDATED: ~~10/31/2014; 12/23/2014; 12/26/2014; 3/17/2015; 4/8/2015; 5/23/2015; 7/29/15; 10/12/2015; 12/28/2015; 1/29/2016; 2/12/2016; 3/31/2016; 4/17/2016; 5/6/2016; 12/11/2016; 7/24/2017; 2/15/2019; (Reformatted) 3/23/2019; 6/20/2019; 7/8/2019; 9/25/2019; 7/7/2021; 12/9/2021;~~ **12/23/2021**