BlueCross BlueShield Federal Employee Program®

TESTOSTERONE (BUCCAL/NASAL/ORAL) PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Testosterone (Buccal/Nasal/Oral)

NOTE: Form must be completed in its **entirety** for processing

Please select the product being requested:

❑**Jatenzo 158mg capsule**	❑**Kyzatrex capsule**	❑**Natesto nasal gel**
❑**Jatenzo 198mg capsule**	❑**Methitest tablet**	❑**Striant buccal system**
❑**Jatenzo 237mg capsule**	❑**Methyltestosterone capsule**	❑**Tlando**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

*****Non-covered branded medications must go through prior authorization and the formulary exception process**

Is this request for brand or generic? ❑Brand ❑Generic

1. How many (bottles/capsules/tablets) will the patient need for a 90 day supply? _____ every 90 days
2. Will this medication be used in combination with any other form of testosterone? ❑Yes* ❑No
   If YES, please specify the medication: _____
3. Is the patient being treated for gender dysphoria (GD), gender identity disorder (GID), sex transformation, or sex change? ***Answer below:***
   ❑**YES**: Is the patient undergoing a female to male transition? ❑Yes ❑No
   ❑**NO**: Please answer the following questions:
   a. Is the patient assigned female or male at birth? ❑Female **OR** ❑Male
   b. What is the patient's diagnosis?
   ❑Delay in sexual development and/or puberty
   i. Will the patient's bone age of the hand and wrist be assessed every 6 months as determined by radiographic evidence? ❑Yes ❑No
   ii. Will the patient's liver functions tests be monitored every 6 months? ❑Yes ❑No
   iii. Will the patient's hematocrit levels be monitored every 6 months? ❑Yes ❑No
   iv. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the last **4 months** excluding samples? ❑Yes ❑No
   ❑Inoperable metastatic breast cancer **OR** ❑Inoperable metastatic mammary cancer
   i. Has the patient received at least one prior therapy for treatment of this condition? ❑Yes ❑No
   ii. Will the patient be monitored for hypercalcemia every 6 months and be advised to discontinue testosterone if found to be present? ❑Yes ❑No
   iii. Will the patient's liver functions tests be monitored every 6 months? ❑Yes ❑No
   iv. Will the patient's hematocrit levels be monitored every 6 months? ❑Yes ❑No
   v. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the last **4 months** excluding samples? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program®

TESTOSTERONE (BUCCAL/NASAL/ORAL) PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Deficiency of testosterone **OR** ❑Hypogonadism **OR** ❑Low testosterone (Low T) **OR**

❑Testicular hypofunction **OR** ❑Androgen deficiency

i. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

1) Has the patient had two morning total testosterone levels less than 300 ng/dL on different days? ❑Yes ❑No

2) What is the patient's hematocrit? _____ % ❑Hematocrit was not tested

3) Does the patient have a current diagnosis of prostate cancer? ❑Yes ❑No

4) Does the patient have palpable prostate nodules? ❑Yes ❑No

5) Has the patient had a prostatectomy? ❑Yes ❑No*****

If NO, what is the patient's baseline prostate specific antigen (PSA)? _____ ng/ml ❑Not tested

6) Does the patient have a concurrent diagnosis of benign prostate hyperplasia (BPH)? ❑Yes***** ❑No

If YES, will the patient be monitored for worsening symptoms of BPH? ❑Yes ❑No

7) Does the patient have a diagnosis of sleep apnea? ❑Yes***** ❑No

If YES, is the patient being treated for their sleep apnea? ❑Yes ❑No

9) Has the prescriber assessed the patient for their cardiovascular risk for myocardial infarction (MI), angina, or stroke? ❑Yes ❑No

10) **Natesto Request**: Does the patient have any chronic nasal conditions or alterations in nasal anatomy? ❑Yes ❑No

❑**YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

1) Does the patient have a total testosterone level 800 ng/dL or less? ❑Yes ❑No

2) Has the patient had a prostatectomy? ❑Yes ❑No

3) Does the patient have a concurrent diagnosis of benign prostate hyperplasia (BPH)? ❑Yes***** ❑No

If YES, have the symptoms associated with BPH worsened since beginning testosterone therapy? ❑Yes ❑No

4) Will the patient's prostate specific antigen (PSA) level be tested every 12 months? ❑Yes ❑No

5) Will the patient's serum testosterone concentrations be monitored every 12 months? ❑Yes ❑No

6) Will the patient's hematocrit levels be monitored every 12 months? ❑Yes ❑No

7) Has the prescriber re-assessed the patient for their cardiovascular risk for myocardial infarction (MI), angina, or stroke? ❑Yes ❑No

❑Other ***(please specify):*** _____