Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

P.O. Box 5119, Helena, MT 59604
Phone 406.443.6002 . Toll-Free 1.800.395.7961
Fax 406.513.1928 . Toll-Free 1.800.294.1350

Montana Healthcare Programs Prior Authorization
For use of Testosterone Containing Products

Member Information	Prescriber Information
Name:	Name:
DOB:	Phone:
Medicaid ID #:	Fax:
Date:	Office Contact for Request:
Drug Being Requested (If requesting Jatenzo or Xyostad, please provide clinical rationale explaining why member cannot use the generic vial for injection or an alternative preferred agent):	

I. Initial Coverage Criteria for Males:

Member must meet ***all of the following criteria***:

1. Member has a diagnosis of hypogonadism due to known condition (i.e., caused from a specific disease state or as a side effect of a medication):

☐ **YES** – Please provide the name of the disease state OR medication causing the hypogonadism:

_____

☐ **NO** – Testosterone therapy ***will not*** be approved.

2. Member must be experiencing at least one clinical sign or symptom of testosterone deficiency (please list symptoms):

_____

_____

3. Provider must submit at least **two TOTAL testosterone** levels drawn before 10 a.m. on two separate days that are <300ng/dl:

- First Testosterone Level: Date _____ Time Drawn _____ Lab Result _____
- Second Testosterone Level: Date _____ Time Drawn _____ Lab Result _____

II. Initial Coverage Criteria for Females:

1. Member must have one of the following diagnoses (not subject to monitoring requirements)

☐ Metastatic breast cancer ☐ Gender non-conforming ☐ Gender dysphoria

☐ Transgender care ☐ Gender transition ☐ Trans-sexual

III. Annual Renewal Coverage Criteria

1. Males:

- A recent testosterone lab result must be submitted:
  - Date: _____ Lab Result: _____
  - The lab should be drawn at the correct time of day, according to the specific product's package insert. See table below for guidelines:

Dosage Form	Lab Monitoring Guidelines
Injectables: testosterone cypionate (Depo-Testosterone®), testosterone enanthate (Delatestryl®)	• Measure serum testosterone level midway between injections.
Transdermal Patches: Androderm®	• Measure morning serum testosterone level (following application the previous evening).
Transdermal Gels/Solutions: AndroGel® 1% or 1.62%, Testim®, Fortesta®, Axiron®	**AndroGel 1% and 1.62% and Testim®:** • Measure pre-dose morning serum testosterone level. **Fortesta®:** • Measure serum testosterone 2 hours after application. **Axiron®:** • Measure serum testosterone 2-8 hours after application.
Buccal Bioadhesive Tablets: Striant®	• Measure pre-dose morning serum testosterone level.

The Endocrine Society recommends annual monitoring to **assure the level does not exceed the therapeutic range.

2. Females:

- Lab monitoring is not required.

Please complete this form in its entirety and fax to:
Drug Prior Authorization Unit at 1-800-294-1350