HIGHMARK HEALTH OPTIONS

Updated: 04/2025
Approved: 04/2025

Request for Prior Authorization for Testosterone Supplementation
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Testosterone Supplementation require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Testosterone Supplementation Prior Authorization Criteria:

Coverage may be provided with a diagnosis of hypogonadism and the following criteria is met:

- The member is a male
- The member had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values
- The member has consistent signs and symptoms of androgen deficiency (e.g. incomplete or delayed sexual development; reduced sexual desire, activity, or spontaneous erections; breast discomfort or gynecomastia; loss of body hair (especially axillary and pubic hair) or reduced need for shaving; very small (< 5 mL) or shrinking testes; inability to father children, low or zero sperm count; height loss, low trauma fracture, low bone mineral density; hot flushes, sweats)
- The member has no contraindications to starting therapy (e.g. breast cancer, prostate cancer, erythrocytosis with hematocrit > 54%, untreated obstructive sleep apnea, severe lower urinary tract symptoms with American Urological Association/International Prostate Symptom Score [IPSS] >21, uncontrolled or poorly controlled heart failure due to risk of increased fluid retention and desire for fertility)
- Baseline PSA, lipids, and hematocrit laboratory levels have been performed
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Men over age 50 years (or over 40 years who have a family history of prostate cancer or are African-American) have been screened for prostate cancer
- Initial Duration of Approval: 6 months
- Reauthorization criteria:
    - Documentation of improvement in signs and symptoms and tolerance to therapy
    - Documentation that normal serum testosterone concentrations are being achieved
    - Repeat PSA, lipids, and hematocrit laboratory levels have been performed and are within normal range
- Reauthorization Duration of Approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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TESTOSTERONE SUPPLEMENTATION PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

☐ **Hypogonadism**, ICD-10: _____

- Is the member 18 years of age or older and a male? ☐ Yes ☐ No
- Are there <u>two</u> confirmed low testosterone levels according to current practice guidelines or the standard lab reference values? ☐ Yes ☐ No
- Are there consistent symptoms and signs of androgen deficiency? ☐ Yes ☐ No
- Does the member have any contraindications to therapy? ☐ Yes ☐ No
- Have baseline PSA, lipids, and hematocrit been performed before initiation of therapy? ☐ Yes ☐ No
- Has the member been screened for prostate cancer (if applicable)? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Is the member demonstrating improvement in symptoms and tolerating therapy? ☐ Yes ☐ No
Has the member achieved a normal serum testosterone level? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date