HIGHMARK HEALTH OPTIONS

Updated: 03/2025
DMMA Approved: 04/2025

Request for Prior Authorization for Testosterone Supplementation
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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:

*NOTE: please reference the Highmark Health Options Gender Transition Services (MP-033-MD-DE) policy for all gender dysphoria requests.

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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product 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: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon Fri 8:00am to 7:00pm

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:

☐ **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

☐ **Other:** _____ ICD-10: _____

REAUTHORIZATION

Is the member demonstrating improvement in symptoms and tolerating therapy? ☐ Yes ☐ No
Has the member achieved a normal serum testosterone level? ☐ Yes ☐ No
Has the member had repeat PSA, lipids, and hematocrit laboratory testing performed and the levels were within normal range?
☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date