COVENTRY Health Care

Testosterone PRIOR AUTHORIZATION FORM

Coverage Policy: Covered as replacement therapy for male members with **testosterone deficiency** when any of the following conditions are met:

1) at least one low total testosterone level (below the normal range for the laboratory) **WITH** elevated FSH and/or LH, **OR**
2) at least two total testosterone levels, both of which are less than normal based upon the laboratory reference range **WITH** at least one low *free* testosterone level (below the normal range for the laboratory), **OR**
3) at least two *free* testosterone levels both of which are less than normal based upon the laboratory reference range, **OR**
4) at least two total testosterone levels both of which are less than normal based upon the laboratory reference range **WITH** normal FSH and/or LH AND evidence of abnormality of the pituitary gland (by MRI or the presence of other deficiency of pituitary hormones).

NOTE: If there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.

Initial Authorization: 3 months at standard dose

Extended Authorization: Retreatment may be initiated for an additional one-year course of therapy with documentation of efficacy and return to normal testosterone levels. Higher quantities will require failure of recommended doses per day.

Reasons for Non-coverage:

- Use for muscle building purposes
- Use in females

Testim is our preferred testosterone replacement agent and is available on Tier 2.

***In health plan(s) where sexual dysfunction treatment is excluded from the benefit, the benefit exclusion will supersede or override any conflicting portion of the testosterone criteria.*

PLEASE SEND COMPLETED FORM TO COVENTRY HEALTH CARE – PHARMACEUTICAL SERVICES

FAX: 866-738-9682 or 717-541-5909 PH: 877-215- 4100

Requesting Physician:	Office Contact:
Call Center ID: Tax ID Number:	Plan ID: Benefit:
Office Fax Number:	Phone Number:
Office Address:	

MEMBER INFORMATION

Patient Name:	DOB:
Member ID#:	Date of Request: July 24, 2008

1.	**Drug Requested:** ☐ **Testim** (Testim is the preferred agent for new starts and Testosterone refills.) ☐*Androderm** ☐*Androgel** ☐ *Striant Buccal** **non-formulary agents* **Dose Requested: _____**
2.	Is this a new prescription? ☐ Yes ☐ No If no, how long has patient been taking medication? _____
3.	Is the patient male? ☐ Yes ☐ No
4.	Is the patient's BMI >30? ☐ Yes ☐ No
5.	**Laboratory results (Lab reports must be attached)** *(Must include lab reports documenting testosterone level prior to initiating replacement therapy.)* ➢ **Total Testosterone Levels:** **1. _____ 2. _____** ➢ **Free Testosterone Levels:** **1. _____ 2. _____** ➢ **LH Level: _____ FSH Level: _____**

Requesting Physician Signature:_____

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Visit our Website at WWW.CVTY.COM

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