



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
 P.O. Box 2586, Worcester, MA 01613-2586  
**Fax:** (877) 208-7428 **Phone:** (800) 745-7318

## Androgen Therapy Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at [www.mass.gov/druglist](http://www.mass.gov/druglist).

### Member information

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
 MassHealth member ID # \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Gender (Check one.)  F  M Member's place of residence  home  nursing facility

### Medication information

#### Medication requested

- |   |   |
|---|---|
| <input type="checkbox"/> Androderm (testosterone patch)               | <input type="checkbox"/> testosterone 2% pump             |
| <input type="checkbox"/> Androgel (testosterone 1% packet)            | <input type="checkbox"/> testosterone cypionate           |
| <input type="checkbox"/> Androgel (testosterone 1.62% packet)         | <input type="checkbox"/> testosterone enanthate           |
| <input type="checkbox"/> Androgel (testosterone 1.62% pump)           | <input type="checkbox"/> testosterone topical solution    |
| <input type="checkbox"/> Aveed (testosterone undecanoate injection)^  | <input type="checkbox"/> Vogelxo (testosterone 1% packet) |
| <input type="checkbox"/> Jatenzo (testosterone undecanoate capsule)   | <input type="checkbox"/> Vogelxo (testosterone 1% pump)   |
| <input type="checkbox"/> methyltestosterone                           | <input type="checkbox"/> Xyosted (testosterone enanthate) |
| <input type="checkbox"/> Natesto (testosterone nasal gel)             | <input type="checkbox"/> Other* _____                     |
| <input type="checkbox"/> Testopel (testosterone intramuscular pellet) |   |
| <input type="checkbox"/> testosterone 1% gel tube                     |   |

**Dose, frequency, and duration of medication requested** \_\_\_\_\_

\* If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).

^This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.

#### Indication (Check all that apply.)

- |  |   |
|--|---|
| <input type="checkbox"/> Delayed puberty | <input type="checkbox"/> Metastatic mammary cancer                |
| <input type="checkbox"/> Hypogonadism    | <input type="checkbox"/> Other (if none of the above apply) _____ |

Please note: MassHealth does not pay for any drug when used for the treatment of male or female sexual dysfunction as described in 130 CMR 406.413(B): Drug Exclusions. For additional information go to: [www.mass.gov/regulations/130-CMR-406000-pharmacy-services](http://www.mass.gov/regulations/130-CMR-406000-pharmacy-services).

Is the member stabilized on the requested medication?  Yes. Please provide start date. \_\_\_\_\_  No

Please indicate billing preference.  Pharmacy  Prescriber in-office  Hospital outpatient

For hospital outpatient billing, provide department-specific facility NPI. \_\_\_\_\_

Drug NDC (if known) or service code \_\_\_\_\_

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**Section I. Please provide any lab test results that confirm the diagnosis as indicated above.**

1. Test \_\_\_\_\_ Lab value \_\_\_\_\_  
Reference range \_\_\_\_\_ Date obtained \_\_\_\_\_
2. Test \_\_\_\_\_ Lab value \_\_\_\_\_  
Reference range \_\_\_\_\_ Date obtained \_\_\_\_\_
3. Test \_\_\_\_\_ Lab value \_\_\_\_\_  
Reference range \_\_\_\_\_ Date obtained \_\_\_\_\_
- 

**Section II. Please complete for Aveed and Xyosted requests.**

1. Has the member tried testosterone enanthate intramuscular injection?
- Yes. Please describe the dates/duration of use and outcome.  
Dates/duration of use \_\_\_\_\_  
Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe the details of adverse reaction, inadequate response, contraindication, or other.  
\_\_\_\_\_
- No
2. Has the member tried testosterone cypionate intramuscular injection?
- Yes. Please describe the dates/duration of use and outcome.  
Dates/duration of use \_\_\_\_\_  
Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe the details of adverse reaction, inadequate response, contraindication, or other.  
\_\_\_\_\_
- No
- 

**Section III. Please complete for Jatenzo and methyltestosterone requests.**

1. Has the member tried two non-injectable formulations of testosterone?
- Yes. Please describe the drug names, dates/duration of use, and outcomes.  
Drug Name \_\_\_\_\_ Dates/duration of use \_\_\_\_\_  
Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe the details of adverse reaction, inadequate response, contraindication, or other.  
\_\_\_\_\_
- No. Please describe if there is a contraindication to all non-injectable formulations of testosterone.  
\_\_\_\_\_
2. For methyltestosterone requests, has the member also tried Jatenzo?
- Yes. Please describe the dates/duration of use, and outcomes. Dates/duration of use \_\_\_\_\_  
Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe the details of adverse reaction, inadequate response, contraindication, or other.  
\_\_\_\_\_
- No. Please describe if there is a contraindication to Jatenzo.  
\_\_\_\_\_
3. For methyltestosterone capsule requests, please provide clinical rationale for use instead of tablet formulation.  
\_\_\_\_\_
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**Section IV. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.**

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

\_\_\_\_\_  
\_\_\_\_\_

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**Prescriber information**

Last name\* \_\_\_\_\_ First name\* \_\_\_\_\_ MI \_\_\_\_\_  
NPI\* \_\_\_\_\_ Individual MH Provider ID \_\_\_\_\_  
DEA No. \_\_\_\_\_ Office Contact Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Telephone No.\* \_\_\_\_\_ Fax No.\* \_\_\_\_\_

\* *Required*

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**Prescribing provider's attestation, signature, and date**

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

**Signature required** \_\_\_\_\_

Printed name of prescribing provider \_\_\_\_\_ Date \_\_\_\_\_