



# Prior Authorization Request Administrative Information

## Member Information

Last name  First name  MI

Member ID  Date of birth

Sex assigned at birth  Female  Male  "X" or Intersex

Current gender  Female  Male  Transgender male  Transgender female  Other

Place of residence  Home  Nursing facility  Other

Race/ethnicity  Preferred spoken language  Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

## Plan Contact Information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

<b>MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, Children's Medical Security Plan, and Health Safety Net Plan</b>
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<input type="checkbox"/> <b>MassHealth Drug Utilization Review Program</b> Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318
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<b>MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)</b>
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<input type="checkbox"/> <b>Fallon Health</b> Online Prior Authorization: <a href="http://go.covermyeds.com/OptumRx">go.covermyeds.com/OptumRx</a> Online Prior Authorization: <a href="http://providerportal.surescripts.net/ProviderPortal/optum">providerportal.surescripts.net/ProviderPortal/optum</a> Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
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<input type="checkbox"/> <b>Health New England</b> Online Prior Authorization: <a href="http://go.covermyeds.com/OptumRx">go.covermyeds.com/OptumRx</a> Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
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<input type="checkbox"/> <b>Mass General Brigham Health Plan</b> Online Prior Authorization (Non-Specialty Drugs): <a href="http://go.covermyeds.com/OptumRx">go.covermyeds.com/OptumRx</a> Online Prior Authorization (Specialty/Medical Drugs): <a href="http://provider.massgeneralbrighamhealthplan.org">provider.massgeneralbrighamhealthplan.org</a> Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555
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<input type="checkbox"/> <b>Tufts Health Plan</b> Online Prior Authorization: <a href="http://point32health.promptpa.com">point32health.promptpa.com</a> Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
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<input type="checkbox"/> <b>WellSense Health Plan</b> Online Prior Authorization: <a href="http://wellsense.org/providers/ma/pharmacy/prior-authorizations">wellsense.org/providers/ma/pharmacy/prior-authorizations</a> Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822
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# 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).

### Medication information

#### Medication requested

- |   |  |
|---|--|
| <input type="checkbox"/> Androderm (testosterone patch)                           | <input type="checkbox"/> testosterone cypionate                    |
| <input type="checkbox"/> Androgel (testosterone 1% packet)                        | <input type="checkbox"/> testosterone enanthate                    |
| <input type="checkbox"/> Androgel (testosterone 1.62% packet)                     | <input type="checkbox"/> testosterone topical solution             |
| <input type="checkbox"/> Androgel (testosterone 1.62% pump)                       | <input type="checkbox"/> Tlando (testosterone undecanoate capsule) |
| <input type="checkbox"/> Aveed (testosterone undecanoate injection) <sup>MB</sup> | <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="text"/>               |
| <input type="checkbox"/> Testopel (testosterone intramuscular pellet)             |  |
| <input type="checkbox"/> testosterone 1% gel tube                                 |  |
| <input type="checkbox"/> testosterone 2% pump                                     |  |

#### 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).

<sup>MB</sup> This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting. MassHealth does not pay for this drug to be dispensed through the retail pharmacy. If listed, prior authorization does not apply through the hospital outpatient and inpatient settings. Please refer to 130 CMR 433.408 for prior authorization requirements for other health care professionals. Notwithstanding the above, this drug may be an exception to the unified pharmacy policy; please refer to respective MassHealth Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs) for prior authorization status and criteria, if applicable.

**Indication** (Check all that apply or include ICD-10 code, if applicable.)

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

Please note: MassHealth does not pay for any drug when used for the treatment of 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

If applicable, please also complete section for professionally administered medications at end of form.

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

1. Test <input type="text"/>	Lab value <input type="text"/>
Reference range <input type="text"/>	Date obtained <input type="text"/>

2. Test	<input type="text"/>	Lab value	<input type="text"/>
	Reference range	<input type="text"/>	Date obtained
3. Test	<input type="text"/>	Lab value	<input type="text"/>
	Reference range	<input type="text"/>	Date obtained

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

1. 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

2. 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

3. For Xyosted requests, is there a contraindication to testosterone cypionate intramuscular injection and testosterone enanthate intramuscular injection?

Yes. Please describe.

No

4. For Xyosted requests, does the member have needle phobia?  Yes  No

If yes, has the member had a trial of two non-injectable formulations of testosterone?

Yes. Please list the drug names, dates/duration of use, and outcomes below.

No. Please describe if there is a contraindication to all non-injectable formulations of testosterone.

Please provide details for the previous trials.

Drug  Dates/duration   Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

Drug  Dates/duration   Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

**Section III. Please complete for Jatenzo, methyltestosterone, and Tlando 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.

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 testosterone undecanoate capsules?

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 testosterone undecanoate capsules.

3. For methyltestosterone capsule requests, please provide medical necessity for use instead of tablet formulation.

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#### Section IV. Please complete for requests for quantities above quantity limits.

Please describe the clinical rationale for exceeding the quantity limit.

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#### Section V. Please complete and provide documentation for exceptions to Step Therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to the member?  Yes  No

If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?

Yes  No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?

Yes  No

If yes, please provide details for the previous trial.

Drug name  Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response

Briefly describe details of adverse reaction or inadequate response.

  

4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in or physical or mental harm to the member?

Yes. Please provide details.

No

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**Please continue to next page and complete Prescriber and Provider Information section.**

# Prior Authorization Request Prescriber and Provider Information

## Prescriber Information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>		
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>				
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>				
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>	Zip	<input type="text"/>
Email address	<input type="text"/>						
Telephone No.*	<input type="text"/>	Fax No.*	<input type="text"/>				

\* Required

## Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>				
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider				
Servicing provider/facility address	<input type="text"/>						
Servicing provider NPI/tax ID No.	<input type="text"/>						
Name of billing provider	<input type="text"/>						
Billing provider NPI No.	<input type="text"/>						
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No			
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>	No. of units	<input type="text"/>

## 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 \_\_\_\_\_

Printed name of prescribing provider  Date

(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)