Aveed

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____kg

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

Send completed form to: Priority Partners Fax: 1-866-212-4756

 Aveed WITH other indications SGM 3918-A – 09/2023.

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org.

Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

❒ Primary hypogonadism, *Continue to 2*

❒ Hypogonadotropic hypogonadism, *Continue to 2*

❒ Age-related hypogonadism, *No further questions*

❒ Late-onset hypogonadism, *No further questions*

❒ Gender dysphoria, *Continue to 9*

❒ Other, please specify. _____, *No further questions*

2. What is the patient's gender?

❒ Biologic male or a person that self identifies as male, *Continue to 3*

❒ Female, *Continue to 3*

3. What is the patient's age?

❒ 18 years of age or older, *Continue to 4*

❒ Less than 18 years of age, *Continue to 4*

4. Is the request for continuation of therapy?
❒ Yes, *Continue to 5*
❒ No, *Continue to 7*

5. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 7*

❒ No, *Continue to 6*

❒ Unknown, *Continue to 7*

6. Before the start of therapy, did the patient have at least two confirmed low morning serum total testosterone concentrations based on reference lab range or current practice guidelines?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. Prior to initiating therapy with the requested drug, did the patient have at least two confirmed (pre-treatment) low morning serum total testosterone concentrations based on reference lab range or current practice guidelines? ***ACTION REQUIRED***: If Yes, attach copy of laboratory report with pretreatment morning serum total testosterone concentrations.

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 8*

❒ No, *Continue to 8*

❒ Unknown, *Continue to 8*

8. Is the copy of the laboratory report with pretreatment morning serum total testosterone concentrations attached to this request?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

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9. Is the patient less than 18 years of age?
❒ Yes, *Continue to 10*
❒ No, *Continue to 11*

10. Is the requested drug prescribed by or in consultation with a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist) that has collaborated care with a mental health provider?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Are the patient's comorbid conditions reasonably controlled?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is the patient able to make an informed decision to engage in hormone therapy?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Has the patient been educated on any contraindications and side effects to therapy?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Is the request for continuation of therapy?
❒ Yes, *Continue to 18*
❒ No, *Continue to 15*

15. Has the patient been informed of fertility preservation options?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Is the requested drug prescribed for gender dysphoria in an adolescent patient?
❒ Yes, *Continue to 17*
❒ No, *No Further Questions*

17. What Tanner stage of puberty has the patient reached?
❒ Tanner stage I, *No further questions*
❒ Tanner stage II, *No further questions*
❒ Tanner stage III, *No further questions*
❒ Tanner stage IV, *No further questions*
❒ Tanner stage V, *No further questions*
❒ Unknown, *No further questions*

18. Is the requested drug prescribed for gender dysphoria in an adolescent patient?
❒ Yes, *Continue to 19*
❒ No, *Continue to 20*

19. Which Tanner stage of puberty has the patient reached previously?

❒ Tanner stage I, *Continue to 20*

❒ Tanner stage II, *Continue to 20*

❒ Tanner stage III, *Continue to 20*

❒ Tanner stage IV, *Continue to 20*

❒ Tanner stage V, *Continue to 20*

❒ Unknown, *No further questions*

20. Has the patient been informed of fertility preservation options before the start of therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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