TRICARE Prior Authorization Request Form for
testosterone undecanoate capsules **(Jatenzo, Kyzatrex, Tlando)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization for initial therapy expires in 1 year. Prior authorization for continuation of therapy for adults does not expire.

Step 1 **Medication requested:** ☐ Jatenzo ☐ Kyzatrex ☐ Tlando

Step 2 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID #: _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 3 **Please complete the clinical assessment:**

1. Will the requested medication be used to enhance athletic performance?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **2**
2. Will the requested medication be used concomitantly with other testosterone products?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes Proceed to question **4**	☐ No Proceed to question **6**
4. Has the patient had a positive response to therapy?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Do the benefits of continued therapy outweigh the risks?	☐ Yes **Sign and date on page 3**	☐ No **STOP** **Coverage not approved**

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6. What is the indication or diagnosis?	☐ Hypogonadism - Proceed to question **7** ☐ Female-to-male gender-affirming hormone therapy in a natal female patient (assigned female at birth) - Proceed to question **14** ☐ Other - Proceed to question **22**	
7. Is the patient male?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have a confirmed diagnosis of hypogonadism as evidenced by morning total serum testosterone levels below 300 ng/dL taken on at least two separate occasions?	☐ Yes Proceed to question **11**	☐ No Proceed to question **10**
10. Is the requested medication being prescribed by an endocrinologist or urologist who has made the diagnosis of hypogonadism based on unequivocally and consistently low serum total testosterone or free testosterone levels?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient experiencing signs and symptoms associated with hypogonadism?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Has the provider investigated the etiology of the low testosterone levels and has assessed the risks versus benefits of initiating testosterone therapy in this patient?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the provider acknowledge that testosterone therapy is clinically appropriate and needed?	☐ Yes Proceed to question **23**	☐ No **STOP** **Coverage not approved**
14. Is the patient greater than or equal to 14 years of age?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Does the patient have a diagnosis of gender dysphoria made by a TRICARE authorized mental health provider according to the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Is the requested medication being prescribed by an endocrinologist or a physician who specializes in the treatment of transgender patients?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**

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17. Is the patient an adult, or an adolescent with sufficient mental capacity to give informed consent for this partially irreversible treatment?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Has the patient experienced puberty to at least Tanner stage 2?	☐ Yes Proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. Is the patient of childbearing potential?	☐ Yes Proceed to question **20**	☐ No Proceed to question **21**
20. Is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **21**
21. Does the patient have a psychiatric comorbidity that would confound a diagnosis of gender dysphoria or interfere with treatment (for example: unresolved body dysmorphic disorder; schizophrenia or other psychotic disorders that have not been stabilized with treatment)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **23**
22. If the indication is not listed above, please write in the requested indication and rationale for use.	_____ Proceed to question **23**	
23. Has the patient tried and failed a 3 month trial of one drug from each of the following two categories: (1) testosterone cypionate IM injection or testosterone enanthate IM injection; (2) testosterone 2% gel (Fortesta) or generic testosterone 1% gel (generic Androgel)?	☐ Yes **Sign and date below**	☐ No Proceed to question **24**
24. Has the patient experienced a clinically significant adverse reaction, or had a contraindication or relative contraindication to one drug from each of the following two categories: (1) testosterone cypionate IM injection or testosterone enanthate IM injection; (2) testosterone 2% gel (Fortesta) or generic testosterone 1% gel (generic Androgel)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 4 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[12 July 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: