# Request for Prior Authorization — Testosterones

Indiana | Anthem Blue Cross and Blue Shield | Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

## Contains confidential patient information

The prescribing provider must complete this form. All sections must be completed, or the request will be returned. Fax to Prior Authorization of Benefits Center at **844-864-7860** (retail) or **888-209-7838** (medical injectable).

Provider Services:

- **866-408-6132** (Hoosier Healthwise)
- **844-533-1995** (Healthy Indiana Plan)
- **844-284-1798** (Hoosier Care Connect)
- **833-569-4739** (Indiana PathWays for Aging)

| Month | Day | Year |
|---|---|---|
| | | |

| | |
|---|---|
| Patient's Medicaid number: | Date of birth: |
| Patient's name: | Prescriber's name: |
| Prescriber's IN license number: | Specialty: |
| Prescriber's NPI number: | Prescriber's signature: |
| Return fax number: | Return phone number: |
| Mark box if requesting retroactive PA: ☐ | Date(s) of service requested for retroactive eligibility (if applicable): |

Note: Submit prior authorization (PA) requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).


INBCBS-CD-086608-25 SRS86026 | July 2025

| Requested medication | Strength | Quantity | Dosage regimen |
|---|---|---|---|
| | | | |

## Depo-testosterone, Testosterone, Cypionate

**Initial authorization:**

1. Please select one of the following:

☐ Member has a diagnosis of delayed puberty

☐ Member has a total testosterone level ≤ 350 ng/dL within the past three months (documentation is required)

2. For **all** indications:

Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No

- Breast cancer in a member assigned male at birth
- Pregnancy
- Prostate cancer

If no, please specify contraindication and medical rationale for use:

_____

_____

**Note**: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and switching formulations to preferred injectable formulation, reauthorization criteria will apply.

**Reauthorization:**

1. Total testosterone level is ≤ 1000 ng/dL within the past six months (Documentation is required):

☐ Yes ☐ No

2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above:

☐ Yes ☐ No

If no, please specify contraindication and medical rationale for use:

_____

_____

## Testosterone Enanthate

## Initial authorization:

1. Please select one of the following:

☐ Member has a diagnosis of delayed puberty:

- Has the member had a previous trial and failure of all preferred injectable testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria)? ☐ Yes ☐ No

If **no**, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____

_____

☐ Member has a total testosterone level ≤ 350 ng/dL within the past three months (Documentation is required):

- Has the member had a previous trial and failure of all preferred injectable testosterone agents (reference PA criteria)? ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____

_____

☐ Member needs medication for palliative treatment of metastatic breast cancer

2. For all indications:
Provider attests that member has none of the following contraindications to therapy:
☐ Yes ☐ No

- Breast cancer in a member assigned male at birth
- Pregnancy
- Prostate cancer

If no, please specify contraindication and medical rationale for use:

_____

_____

**Note**: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and are switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply.

## Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six months (Documentation is required):

☐ Yes ☐ No

2. Has the member had a previous trial and failure of at least one preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (not required for palliative treatment of breast cancer) [reference PA criteria]? ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____

_____

3. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above: ☐ Yes ☐ No

If no, please specify contraindication and medical rationale for use:

_____

_____

## Aveed, Testopel, Pellet, Xysoted
## Initial authorization:

1. Please select one of the following:

☐ Member has a diagnosis of delayed puberty:

- Has the member had a previous trial and failure of all preferred injectable testosterone agents, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria)? ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____

_____

☐ Member has a total testosterone level ≤ 350 ng/dL within the past three months (Documentation is required):

- Has the member had a previous trial and failure of all preferred injectable testosterone agents (reference PA criteria)? ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____
_____

2. For all indications:

Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No

- Breast cancer in a member assigned male at birth
- Hypogonadal conditions not associated with structural or genetic etiologies (Xyosted ONLY)
- Pregnancy
- Prostate cancer

If no, please specify contraindication and medical rationale for use:

_____
_____

**Note**: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and is switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply.

## Reauthorization:

1. Total testosterone level is ≤1000 ng/dL within the past six months (Documentation is required):

☐ Yes ☐ No

2. Has the member had a previous trial and failure of at least one preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria)? ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____
_____

3. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above:

☐ Yes ☐ No

If no, please specify contraindication and medical rationale for use:
_____
_____

## Androdern, Testosterone 1% (25 mg)/ 2.5 gm Gel Packets, Testosterone 1% (12.5 mg)/ Act gel pump, Testosterone 1.62% (20.25 mg)/ Act metered pump gel, Testim 1% (50 mg)/ 5 gm gel pump, Testosterone 1.62% (20.25 mg)/ Act metered pump gel, Testim 1% (50 mg)/ 5 gm gel pump,

### Initial authorization:

1. Please select one of the following:

☐ Member is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past three months (Documentation is required), and is requesting to use topical testosterone within the established quantity limits: ☐ Yes ☐ No

Requested dose: _____

☐ Member is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical testosterone therapy (documentation is required), and is requesting to exceed established quantity limits: ☐ Yes ☐ No

Requested dose: _____

Member has used ≥ 14 days of topical testosterone therapy: ☐ Yes ☐ No

Name of medication: _____

Dose: _____

Start and end date: _____

If no, please provide medical justification as to why member is requesting a dose beyond established quantity limits:
_____
_____

2. For all indications:

Provider attests that member has none of the following contraindications to therapy: ☐ Yes ☐ No

Breast cancer in a member assigned male at birth

- Pregnancy
- Prostate cancer

If no, please specify contraindication and medical rationale for use:

_____

_____

**Note**: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and is switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply.

## Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six months (Documentation is required):

☐ Yes ☐ No

2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above: ☐ Yes ☐ No

If no, please specify contraindication and medical rationale for use:

_____

_____

**Note**: dose requested for reauthorization should not exceed established quantity limits unless member historically has been approved to exceed the established quantity limits.

Requested dose: _____

## Natesto, testosterone 1% (50 mg)/5 gm gel packets/tubes, testosterone 1.62% (40.5 mg)/2.5 gm gel packets, testosterone 1.62% (20.25 mg)/1.25 gm gel packets, testosterone 2% (10 mg)/act metered pump, testosterone 30 mg/act solution, Vogelxo 1% (50 mg)/5 gm gel packets, Vogelxo 1% (12.5 mg)/act gel pump.

## Initial authorization:

1. Please select one of the following:

☐ Member is 16 years of age or older, has a total testosterone level ≤ 350 ng/dL within the past three months (documentation is required), and is requesting to use topical testosterone within the established quantity limits: ☐ Yes ☐ No

Requested dose: _____

☐ Member is 16 years of age or older, has a total testosterone level ≤ 400 ng/dL while on topical testosterone therapy (Documentation is required), and is requesting to exceed established quantity limits: ☐ Yes ☐ No

Requested dose: _____

Member has used ≥ 14 days of topical testosterone therapy: ☐ Yes ☐ No

Name of medication: _____

Dose: _____

Start and End date: _____

If no, please provide medical justification as to why member is requesting a dose beyond established quantity limits:

_____

_____

2. Previous trial and failure of all preferred topical testosterone agents, as confirmed by claims history, chart documentation, or provider attestation, including dates of trial (reference PA criteria): ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred topical testosterone agents:

_____

_____

3. For all indications:
Provider attests that member has none of the following contraindications to therapy:
☐ Yes ☐ No

- Breast cancer in a member assigned male at birth
- Pregnancy
- Prostate cancer

If no, please specify contraindication and medical rationale for use:

_____

_____

**Note**: If member has had history with injectable/topical product within the past 120 days, confirmed by claims history, and is switching formulations to nonpreferred injectable formulation, reauthorization criteria will apply.

## Reauthorization:

1. Total testosterone level is ≤1000 ng/dL within the past six months (Documentation is required):

☐ Yes ☐ No

2. Previous trial and failure of at least one preferred topical testosterone agent, as confirmed by claims history, chart documentation, or provider attestation, including dates of trial (reference PA criteria):

☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred topical testosterone agents:

_____

_____

3. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above:

☐ Yes ☐ No

If no, please specify contraindication and medical rationale for use:

_____

_____

**Note**: dose requested for reauthorization should not exceed established quantity limits unless member historically has been approved to exceed the established quantity limits.

Requested dose: _____

## Danazol

## Initial authorization (approval up to six months):

1. Member diagnosis(es): _____

**Note**: Approvable diagnoses include angioedema prophylaxis for heredity angioedema, autoimmune hemolytic anemia, discoid lupus erythematosus, endometriosis, fibrocystic breast disease, myelosclerosis with myeloid metaplasia.

2. For all indications:

Provider attests that member has none of the following contraindications to therapy:

☐ Yes ☐ No

- Active or history of thrombosis or thromboembolic disease
- Androgen-dependent tumor
- Cardiac disease
- Porphyria
- Pregnancy or breast-feeding
- Severe hepatic disease
- Severe renal disease
- Undiagnosed genital bleeding

If no, please specify contraindication and medical rationale for use:

_____

_____

## Reauthorization (approval up to six months):

1. Documentation from prescriber indicating continued benefit from the medication without significant adverse events: ☐ Yes ☐ No

2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above:

☐ Yes ☐ No

If no, please specify contraindication and medical rationale for use:

_____

_____

## Jatenzo (testosterone undecanoate)

## Initial authorization:

1. Member is 18 years of age or older and is requesting to use oral testosterone within the established quantity limits: ☐ Yes ☐ No

Requested dose: _____

2. Member has a diagnosis of hypogonadism with a total testosterone level ≤ 350 ng/dL within the past three months (Documentation is required): ☐ Yes ☐ No

3. Previous trial and failure of at least one preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation, including dates of trial (reference PA criteria): ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____

_____

4. For all indications:

Provider attests that member has none of the following contraindications to therapy:
☐ Yes ☐ No

- Breast cancer in a member assigned male at birth
- Hypogonadal conditions not associated with structural or genetic etiologies
- Pregnancy
- Prostate cancer

If no, please specify contraindication and medical rationale for use:

_____

_____

## Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six months (Documentation is required):

☐ Yes ☐ No

2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above:
☐ Yes ☐ No

If no, please specify contraindication and medical rationale for use:

_____

_____

3. Previous trial and failure of at least one preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation, including dates of trial (reference PA criteria): ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____

_____

**Note**: dose requested for reauthorization should not exceed established quantity limits.

Requested dose: _____

## Methitest (methyltestosterone)
## Initial authorization (approval up to six months):

1. Please select one of the following:

☐ Member has a diagnosis of cryptorchidism.

☐ Member has a diagnosis of delayed puberty.

☐ Member has a diagnosis of hypogonadism (primary or hypogonadotropic) with a total testosterone
≤ 350 ng/dL within the past three months (Documentation is required).

☐ Member needs medication for palliative treatment of metastatic breast cancer.

2. Previous trial and failure of at least ONE preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria): ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____

_____

3. For all indications:
Provider attests that member has none of the following contraindications to therapy:
☐ Yes ☐ No

- Breast cancer in a member assigned male at birth
- Pregnancy
- Prostate cancer

If no, please specify contraindication and medical rationale for use:

_____

_____

4. Dose requested of methyltestosterone is within the established quantity limits: ☐ Yes ☐

No

Requested dose: _____

## Reauthorization (approval up to six months):

1. Please select one of the following:

☐ Member has a diagnosis of hypogonadism and a total testosterone level ≤ 1000 ng/dL within the past six months (Documentation is required).

☐ Member has a diagnosis of delayed puberty, palliative treatment of metastatic breast cancer, or cryptorchidism and prescriber has submitted documentation indicating continued benefit from the medication without significant adverse events.

2. For all indications:
Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above: ☐ Yes ☐ No

If no, please specify contraindication and medical rationale for use:

_____

_____

3. Previous trial and failure of at least one preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria): ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____

_____

**Note**: dose requested for reauthorization should not exceed established quantity limits.

Requested dose: _____

## Tlando (testosterone undecanoate)

## Initial authorization:

1. Member is 18 years of age or older and is requesting to use oral testosterone within the established quantity limits: ☐ Yes ☐ No

Requested dose: _____

2. Member has a diagnosis of hypogonadism and a total testosterone level ≤ 350 ng/dL within the past three months (Documentation is required): ☐ Yes ☐ No

3. Previous trial and failure of at least ONE preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria): ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____

_____

4. For all indications:
Provider attests that member has none of the following contraindications to therapy:
☐ Yes ☐ No

- Breast cancer
- Hypogonadal conditions not associated with structural or genetic etiologies
- Pregnancy
- Prostate cancer

If no, please specify contraindication and medical rationale for use:

_____

_____

## Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six months (Documentation is required):

☐ Yes ☐ No

2. Prescriber attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above:
☐ Yes ☐ No

If no, please specify contraindication and medical rationale for use:

_____

_____

3. Previous trial and failure of at least one preferred injectable testosterone agent, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria): ☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over all preferred injectable testosterone agents:

_____

_____

**Note**: dose requested for reauthorization should not exceed established quantity limits.

Requested dose: _____

## Undecatrex (testosterone undecanoate)

## Initial authorization:

1. Member is 18 years of age or older and is requesting to use oral testosterone within the established quantity limits: ☐ Yes ☐ No
Requested dose: _____

2. Member has a diagnosis of hypogonadism with a total testosterone level ≤ 350 ng/dL within the past three months (Documentation is required): ☐ Yes ☐ No

3. Previous trial and failure of both Jatenzo and Tlando, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria):
☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over Jatenzo and Tlando: _____
_____

4. For all indications:
Provider attests that member has none of the following contraindications to therapy:
☐ Yes ☐ No

- Breast cancer in a member assigned male at birth
- Hypogonadal conditions not associated with structural or genetic etiologies
- Pregnancy
- Prostate cancer

If no, please specify contraindication and medical rationale for use:
_____
_____

## Reauthorization:

1. Total testosterone level is ≤ 1000 ng/dL within the past six months (Documentation is required):
☐ Yes ☐ No

2. Provider attests that member remains a candidate for treatment, indicating that they have not developed any of the contraindication(s) listed under initial authorization above:
☐ Yes ☐ No

If no, please specify contraindication and medical rationale for use:
_____
_____

3. Previous trial and failure of both Jatenzo and Tlando, as confirmed by claims history, chart documentation, or provider attestation including dates of trial (reference PA criteria):
☐ Yes ☐ No

If no, please provide medical justification for use of requested agent over Jatenzo and Tlando: _____
_____

**Note**: dose requested for reauthorization should not exceed established quantity limits.

Requested dose: _____

## Confidential information



**Email is the quickest and most direct way to receive important information from us.**

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the left or via our online form: http://anthem.ly/signup-abcbs-in.