Print Clear

Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

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.

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

☐ Androderm (testosterone patch)
☐ Androgel (testosterone 1% packet)
☐ Androgel (testosterone 1.62% packet)
☐ Androgel (testosterone 1.62% pump)
☐ Aveed (testosterone undecanoate)^
☐ Natesto (testosterone nasal gel)
☐ Striant (testosterone buccal system)
☐ Testopel (testosterone intramuscular pellet)
☐ testosterone 1% gel tube
☐ testosterone 2% pump
☐ testosterone cypionate
☐ testosterone enanthate
☐ testosterone topical solution
☐ Vogelxo (testosterone 1% packet)
☐ Vogelxo (testosterone 1% pump)
☐ Other* _____

Dose, frequency, and duration of medication requested _____

Is the member stabilized on the requested medication? ☐ Yes. Please provide start date. _____ ☐ No.

** 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.)

☐ Delayed puberty
☐ Hypogonadism
☐ Metastatic mammary cancer
☐ 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.

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 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.

_____

_____

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*

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 _____