Aveed® (testosterone undecanoate injection) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: ________________ Phone: ________ Fax: ________

A. PATIENT INFORMATION

First Name: | Last Name: | DOB:
Address: | City: | State: | ZIP:
Home Phone: | Work Phone: | Cell Phone: | Email:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms | Allergies:

B. INSURANCE INFORMATION

Aetna Member ID #: ________________
Group #: ________________
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: ________ Carrier Name: ________________
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name: | Last Name: | *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.
Address: | City: | State: | ZIP:
Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN:
Provider Email: | Office Contact Name: | Phone:

Specialty *(Check one)*: ☐ **Endocrinologist** ☐ **Internist** ☐ **Other**: ________________

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ________________
Center Name: ________________
☐ Home Infusion Center Phone: ________________
Agency Name: ________________
☐ Administration code(s) (CPT): ________________
Address: ________________

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other ________________
Name: ________________
Address: ________________
Phone: ________________ Fax: ________________
TIN: ________________ PIN: ________________

E. PRODUCT INFORMATION

Request is for: Aveed (testosterone undecanoate injection) Dose: ________________ **Frequency:** ________________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ________________ **Secondary ICD Code:** ________________ **Other ICD Code:** ________________

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required):

☐ Yes ☐ No Has the patient had an ineffective response, contraindication, or intolerance to Depo-Testosterone?

For Initiation Requests (clinical documentation required):

☐ **Gender dysphoria**
- ☐ Yes ☐ No Is the patient less than 18 years of age?
  - → ☐ Yes ☐ No 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 care provider?
- ☐ Yes ☐ No Are the patient's comorbid conditions reasonably controlled?
- ☐ Yes ☐ No Is the patient able to make an informed decision to engage in hormone therapy?
- ☐ Yes ☐ No Has the patient been educated on any contraindications and side effects to therapy?
- ☐ Yes ☐ No Has the patient been informed of fertility preservation options?
- ☐ Yes ☐ No Is the requested drug prescribed for gender dysphoria in an adolescent patient?
  - → Please indicate the Tanner stage of puberty the patient has reached:
    ☐ Tanner stage I ☐ Tanner stage II ☐ Tanner stage III ☐ Tanner stage IV ☐ Tanner stage V ☐ Unknown

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Primary hypogonadism** ☐ **Hypogonadotropic hypogonadism** ☐ **Age-related hypogonadism** ☐ **Late-onset hypogonadism**
☐ **Other:** ____________________

Please indicate the patient's gender: ☐ Biologic male or a person that self identifies as male ☐ Female

☐ Yes ☐ No ☐ Unknown 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?

☐ Yes ☐ No Is the copy of the laboratory report with pretreatment morning serum total testosterone concentrations attached to this request?

For Continuation Requests (clinical documentation required):

☐ **Gender dysphoria**

☐ Yes ☐ No Is the patient less than 18 years of age?
→ ☐ Yes ☐ No 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 care provider?

☐ Yes ☐ No Are the patient's comorbid conditions reasonably controlled?
☐ Yes ☐ No Is the patient able to make an informed decision to engage in hormone therapy?
☐ Yes ☐ No Has the patient been educated on any contraindications and side effects to therapy?
☐ Yes ☐ No Has the patient been informed of fertility preservation options before the start of therapy?
☐ Yes ☐ No Is the requested drug prescribed for gender dysphoria in an adolescent patient?
→ Please indicate the Tanner stage of puberty the patient has reached:
☐ Tanner stage I ☐ Tanner stage II ☐ Tanner stage III ☐ Tanner stage IV ☐ Tanner stage V ☐ Unknown

☐ **Primary hypogonadism** ☐ **Hypogonadotropic hypogonadism** ☐ **Age-related hypogonadism** ☐ **Late-onset hypogonadism**
☐ **Other:** ____________________

☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
Please indicate the patient's gender: ☐ Biologic male or a person that self identifies as male ☐ Female
☐ Yes ☐ No 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?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: ____________________ **Date:** ___/___/___

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.