HEALTH PLANS
UNIVERSITY OF UTAH

Healthy U
Health Choice Utah

PRIOR AUTHORIZATION REQUEST FORM
TESTOPEL®

For authorization, please answer each question and fax this form PLUS chart notes back to Medicaid Prior Authorization Department.

- Healthy U: 801-213-1547
- Health Choice Utah: 801-646-7300

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 833-981-0212
- Health Choice Utah: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Testopel® (testosterone pellets)

Please note that testosterone injectable and topical testosterone are the plans preferred products.

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the member male?	☐	☐	
3. Does the member have a confirmed diagnosis of one of the following? • Primary hypogonadism • Hypogonadotropic hypogonadism	☐	☐	**Please provide documentation**
4. Does the member have 2 confirmed early morning low serum testosterone levels at least 24 hours apart, defined as one of the following: • Total testosterone(TT) <464ng/dL (9.2nmol/L) for CDC certified TT assays • Free testosterone (FT) level less than the laboratory's normal reference range	☐	☐	**Please provide documentation**
5. Has the member had at least a 6-month trial and failure of injectable testosterone?	☐	☐	**Please provide documentation**
6. Has the member had at least a 6-month trial and failure of topical testosterone?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show continued medical necessity and that the treatment is effective?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
PRESCRIBER CERTIFICATION			
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.			
Physician's Signature:			**Date:**

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Policy: PHARM-MM-M008
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/08/2026
Next Review Date: 04/08/2027
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