Nevada Medicaid – Molina Healthcare

Xyosted™ Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			**Provider Information (required)**		
Member Name:			Provider Name:		
Molina ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Gender dysphoria

❑ Hypogonadism (e.g., testicular hypo function; male hypogonadism; ICD-10 E29.1)

❑ Other diagnosis:_____ ICD-10 Code(s): _____

Hypogonadism (for example; testicular hypo function; male hypogonadism; ICD-10 E29.1):

Was the member male at birth? ☐ **Yes** ☐ **No**

Does the member have TWO pre-treatment serum total testosterone levels less than 300 ng/dL (< 10.4 nmol/L) or less than the reference range for the lab? ☐ **Yes** ☐ **No**

Does the member have ONE pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (< 0.17 nmol/L) or less than the reference range from the lab? ☐ **Yes** ☐ **No**

Does the member have a condition that may cause altered sex hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV, liver disorder, diabetes, obesity)? ☐ **Yes** ☐ **No**

Does the member have a history of any of the following: Bilateral orchiectomy, Panhypopituitarism, Genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)? ☐ **Yes** ☐ **No**

Gender dysphoria:

Is the member's gender dysphoria defined by the current version of the Diagnostic and Statistical Manual of Mental Disorder (DSM)? ☐ **Yes** ☐ **No**

Is the member using the hormones to change their physical characteristics? ☐ **Yes** ☐ **No**

Is the member a female-to-male transsexual? ☐ **Yes** ☐ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.

Office use only: Xyosted_NevadaMedicaid_2019Aug-W