Tricare Prior Authorization Request Form for

Androgel, testosterone 1% and 1.62% gel MDP and gel packets, 2% testosterone solution MDP, 1% testosterone gel in unit-dose tubes (Testim, Vogelxo, generics)

5692

To be completed and signed by the prescriber.

Martin's Point

Clinical Documentation is required for a determination to be made.

Please fax completed form back to: (207) 828-7816

Initial therapy approves for 1 year, renewal approves indefinitely. For renewal of therapy, an initial Tricare prior authorization approval is required.

Step 1

Please complete patient and physician information (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2

Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient had a positive response to therapy and do the benefits of continued therapy outweigh the risks?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. What is the indication or diagnosis?	☐ Hypogonadism in males - Proceed to question **4** ☐ Female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth) - Proceed to question **8** ☐ Postmenopausal female hypoactive sexual desire disorder - Proceed to question **20** ☐ Other - Proceed to question **15**	
4. Is the patient 18 years of age or older?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a confirmed diagnosis of hypogonadism as evidenced by morning total serum testosterone levels below 300 ng/dL taken on at least two separate occasions?	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**

6. Is testosterone being prescribed by an endocrinologist or urologist who has made the diagnosis of hypogonadism based on unequivocally and consistently low serum total testosterone or free testosterone levels?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient experiencing signs and symptoms associated with hypogonadism?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
8. Is the indication for initiation or continuation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)?	☐ Initiation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)- Proceed to question **9** ☐ Continuation of female-to-male gender dysphoria hormone therapy in a natal female patient (assigned female at birth)- Proceed to question **10**	
9. Is the patient a female active duty servicemember?	☐ Yes (Female active duty servicemembers) – **STOP - Coverage not approved** ☐ No (Female non-active duty servicemembers) - Proceed to question **10**	
10. Is the patient 19 years of age or older?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have a diagnosis of gender dysphoria made by a TRICARE-authorized mental health provider according to the most current edition of the DSM?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the requested medication being prescribed by an endocrinologist or a physician who specializes in the treatment of transgender patients?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient a biological female of childbearing potential and is the patient pregnant or breastfeeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Does the patient have a psychiatric comorbidity that would confound a diagnosis of gender dysphoria or interfere with treatment (for example: unresolved body dysmorphic disorder; schizophrenia or other psychotic disorders that have not been stabilized with treatment)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **16**
15. Document the requested indication and rationale for use. Note: Enhancing athletic performance alone is not an approved indication.	_____ Proceed to question **16**	

16. What is the requested medication? Note: Use of multiple testosterone products simultaneously is not authorized	☐ testosterone 1% gel (for example, generic Androgel, generic Testim, etc.) - **Sign and date below** ☐ testosterone 1.62% gel (for example, generic Androgel, etc.) - **Sign and date below** ☐ testosterone 2% solution (for example, generic Axiron, etc.) - **Sign and date below** ☐ Other (for example Androderm, Fortesta (2% testosterone gel multi-dose pump (MDP)), Natesto, brand Testosterone 1% gel packet, brand Vogelxo) - Proceed to question **17**	
17. Has the patient tried and failed a 3-month trial of one of the following medications: testosterone 1% gel (for example, generic Androgel, generic Testim, etc.), 1.62% gel (for example, generic Androgel, etc.), or 2% solution (for example, generic Axiron, etc.)?	☐ Yes **Sign and date below**	☐ No Proceed to question **18**
18. Has the patient experienced a clinically significant adverse reaction to one of the following medications: testosterone 1% gel (for example, generic Androgel, generic Testim, etc.), 1.62% gel (for example, generic Androgel, etc.), or 2% solution (for example, generic Axiron, etc.)?	☐ Yes **Sign and date below**	☐ No Proceed to question **19**
19. Has the patient had a contraindication or relative contraindication to one of the following medications: testosterone 1% gel (for example, generic Androgel, generic Testim, etc.), 1.62% gel (for example, generic Androgel, etc.), or 2% solution (for example, generic Axiron, etc.)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
20. What is the requested medication? Note: Use of multiple testosterone products simultaneously is not authorized	☐ testosterone 1% gel (for example, generic Androgel, generic Testim, etc.) - **Sign and date below** ☐ Other – **STOP - Coverage not approved**	

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[14 August 2026]

Please attach office notes (clinical documentation)