

Nevada Medicaid - Molina Healthcare

HEALTHCARE

XyostedTM 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.

Mem	ber Information	(required)	Provid	er Infor	mation	(required)
Member Name:			Provider Information (required) 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:		Zip:	
Medication Information (required)						
Medication Name:			Strength: Dosage Form:		orm:	
☐ 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 dysphori		·	,			
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.						

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