Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Xyosted™ Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance 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 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-855-455-3303.

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