

Commercial PA Criteria

Effective: May 2004

Prior Authorization: Testosterone

Products Affected: Androgel, Aveed, Azmiro, Methyltestosterone, Natesto, Testim, Testopel, Testosterone pellet, Testosterone Cream (brand name only), Vogelxo, Xyosted

Covered Uses:

1. Primary hypogonadism (congenital or acquired)
2. Hypogonadotropic hypogonadism (congenital or acquired)

Exclusion Criteria:

1. Sexual dysfunction, per pharmacy rider
2. Use in fatigue, malaise, depression, and other non-specific and non-FDA approved uses

Required Medical Information:

1. Diagnosis
2. Baseline total testosterone lab result
3. Past medication trials

Age Restrictions: N/A

Prescriber Restrictions: N/A

Coverage Duration: 12 Months*

* Authorizations for **Testopel/Testosterone pellet** will be granted for 2 implants over 1 year. Additional implants may be approved with documented need.

Other Criteria: ConnectiCare considers **Androgel** to be medically necessary in males when the following criteria is met:

1. Patient has a lack of testosterone, due to injury, surgery, trauma, tumor, radiation to the pituitary, or bilateral cryptorchidism, torsion, or infection; confirmed by the below:
 - a. Total testosterone level <240 ng/ LH, FSH, and prolactin L (for patients with a BMI >29 a free testosterone level must also be measured) - a copy of lab must be provided

OR

2. Use in treatment of male osteoporosis with objective data (BMD results) that support use, in association with hypotestosterone levels;

OR

3. Member has gender dysphoria or undergoing gender reassignment surgery and is concomitantly receiving mental health services.

AND

4. For all other testosterone products: patient must have had an intolerance to, or treatment failure of a preferred formulary testosterone product.

December 2024



References:

1. Facts and Comparisons Online

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	5/2004
2	Policy Revision	Updated Template from CCI to EH CCI P&T Review History:3/04, 6/07, 6/08, 9/09, 9/10, 4/11, 12/11, 10/12, 10/13, 10/14, 11/15, 2/16, 2/17, 5/17, 1/18 CCI Revision Record:12/08, 4/11, 5/12, 10/13, 1/14, 4/14, 6/14, 12/14, 10/15, 2/17, 5/17, 1/18, 1/19	All	4/25/2019
3	Policy Update	Removed Aveed, adopted EH Medical Policy	Products Affected	11/13/19
4	Update	Added Testosterone pellet to products affected Added Testosterone pellet to coverage duration	Products Affected Coverage duration	12/17/2020
5	Update	Removal of obsolete products – Androderm, Fortesta, Android, Striant, Testoderm Addition of Aveed to products affected Removed Androgel as a preferred step through product to now read "preferred formulary testosterone product"	Products Affected Other Criteria	12/26/2024