Washington State Health Care Authority

Androgenic Agents –
Testosterone Replacement Therapy (TRT)

Medical policy no. 23.10.00-2 Effective: October 1, 2020

Note*:* New-to-market drugs in this class are non-preferred and subject to this prior authorization (PA) policy. Non-preferred agents in this class, require an inadequate response or documented intolerance due to severe adverse reaction or contraindication to at least TWO preferred agents. If there is only one preferred agent in the class documentation of inadequate response to ONE preferred agent is needed.

Background:

The Food and Drug Administration (FDA) approved testosterone products for testosterone replacement therapy in males with primary or secondary hypogonadism (congenital or acquired). Primary hypogonadism originates from a deficiency or disorder in the testicles. Secondary hypogonadism indicates a problem in the hypothalamus or the pituitary gland. Testosterone may also be used in the treatment of other conditions, such as delayed puberty, metastatic breast cancer, and gender dysphoria.

Medical necessity

Drug	Medical Necessity

Testosterone
• Androderm (Transdermal patch, ER)
• AndroGel (Topical gel)
• generic (Topical solution)
• Fortesta (Topical gel)
• generic (Topical gel)
• Striant (Buccal patch, ER)
• Testim (Topical gel)
• Testopel (Pellets)
• Vogelxo (Topical gel)
 	
Methyltestosterone
• Methitest (Oral tablet)
• generic (Oral capsule)
 	
Testosterone enanthate
• generic (IM injection)
• Xyosted (Auto-injector)
 	
Testosterone undecanoate
• Aveed (Injectable solution)
• Jatenzo (Oral capsules)
 	
Testosterone cypionate
• Depo-Testosterone (IM Injection)
• generic (IM injection)
	Testosterone may be considered medically necessary when used for the following indications:
	
	• Testosterone Replacement Therapy (TRT) for adult males for the following conditions:
	  ○ Primary hypogonadism (congenital or acquired)
	  ○ Secondary hypogonadism (congenital or acquired)
	  ○ Biologic males with severely low testosterone who are symptomatic.
	  ○ HIV-associated weight loss
	  ○ Chronic, high-dose glucocorticoid-therapy
	  ○ Biologic males with osteoporosis or who are under 50 years old with low trauma fractures
	
	• Delayed puberty
	
	• Metastatic breast cancer
	
	• Gender dysphoria (transgender health)
	  ○ For details, please see the Transgender Health Services section of the Physician-Related Services/Health Care Professional Services Billing Guide.

Clinical policy:

Clinical Criteria	
Testosterone Replacement Therapy for Adult Males ○ Primary hypogonadism ○ Secondary hypogonadism ○ Biologic males with severely low testosterone who are symptomatic ○ HIV-associated weight loss ○ Chronic, high-dose glucocorticoid-therapy ○ Biologic males with osteoporosis or who are under 50 with low trauma fractures	Testosterone Replacement Therapy (TRT) may be considered medically necessary when patients meet **ALL** of the following criteria: 1. Patient is biologically male, 18 years of age or older; **AND** 2. Patient has had **TWO** morning (between 8 a.m. to 10 a.m.) tests (between at least 1 week but no more than 3 months apart) at baseline demonstrating low testosterone levels. Second morning test should follow ruling out reversible illnesses, drugs, and nutritional deficiencies as causes for low testosterone. Low testosterone is defined by **ONE** following criteria: a. Total serum testosterone level less than 300ng/dL (10.4nmol/L); **OR** b. Total serum testosterone level less than 350ng/dL (12.1nmol/L) **AND** free serum testosterone level less than 50pg/mL (or 0.174nmol/L); **AND** 3. Patient has recent LH and FSH labs to guide diagnosis as primary or secondary hypogonadism; **AND** 4. Patient has received **ONE** of the following diagnoses: a. **Primary hypogonadism** (congenital or acquired) defined as testicular failure due to conditions such as: i. cryptorchidism, ii. bilateral torsion, iii. orchitis, iv. vanishing testes syndrome, v. orchiectomy, vi. Klinefelter syndrome, vii. chemotherapy, viii. trauma, or ix. toxic damage from alcohol or heavy metals; **OR** b. **Secondary hypogonadism** (congenital or acquired) defined as idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency, or pituitary-hypothalamic injury from tumors, trauma or radiation; **OR** c. **Biologic males with severely low testosterone who are symptomatic** defined as two tests with total serum testosterone levels less than 100 ng/dL **AND** presence of physical signs of hypogonadism, defined as significant decrease in bone or muscle mass in the last 6 months; **OR** d. **HIV-associated weight loss** defined as <90% of ideal body weight (IBW) or weight loss of >10% in the last 6 months while diagnosed with HIV i. The following documentation is required for approval: 1) diagnosis of HIV; 2) most recent weight, ideal body weight, and any documentation of weight loss over the last 6 months;

3) target body weight goal; **OR**

e. **Chronic, high-dose glucocorticoid-therapy** defined as more than 5 mg/day of prednisone or equivalent daily for greater than two (2) weeks
   i. The following documentation is required for approval:
      1) diagnosis requiring glucocorticoid regimen;
      2) current glucocorticoid regimen;
      3) expected duration of therapy; **OR**

f. **Biologic males with osteoporosis or who are under 50 with low trauma fractures**
   i. The following documentation is required for approval:
      1) diagnosis of osteoporosis or low trauma fracture within the previous 12 months
      2) patient is currently being treated for osteoporosis or low trauma fracture; **AND**

5. Patient meets **ALL** of the following criteria:
   a. Patient does not have **ANY** of the following contraindications to testosterone therapy:
      i. breast cancer or known or suspected prostate cancer
      ii. elevated hematocrit (>50%)
      iii. untreated severe obstructive sleep apnea
      iv. severe lower urinary tract symptoms
      v. uncontrolled or poorly-controlled heart failure
   b. Patient has not experienced a major cardiovascular event (e.g., myocardial infraction, stroke, acute coronary syndrome, etc.) in the previous 6 months
   c. Patient does not have uncontrolled or poorly-controlled benign prostate hyperplasia or is at a higher risk of prostate cancer (e.g., elevation of PSA after initiating TRT)

If **ALL** criteria are met, then the request can be approved for the appropriate duration for the indicated treatment:

- **Primary hypogonadism:** approve 12 months
- **Secondary hypogonadism:** approve 12 months
- **Biologic males with severely low testosterone who are symptomatic:** approve 12 months
- **HIV-associated weight loss:** approve 6 months
- **Chronic, high-dose glucocorticoid-therapy:** approve up to the duration of the expected regimen of chronic, high-dose glucocorticoid-therapy with a maximum of 12 months.
- **Biologic males with osteoporosis or young men with low trauma fractures:** approve 12 months

Criteria (Reauthorization)

Testosterone may be approved for reauthorization when **ALL** of the following are met:

	1. Patient continues to meets criteria 4 and 5 of the initial criteria above; **AND** 2. Patient has not experienced any severe adverse events due to testosterone therapy; **AND** 3. Patient's most recent testosterone labs show that serum testosterone concentration is in the normal range since starting therapy; **AND** 4. Patient has documentation of positive clinical response as defined by the criteria below for each indication: a. **HIV-associated weight loss:** patient has shown an increase in body weight and **ONE** of the following: i. is not yet at target body weight goal; **OR** ii. patient is still experiencing an episode (e.g., a secondary infection) that is causing weight loss; b. **Chronic, high-dose glucocorticoid-therapy:** high-dose glucocorticoid therapy is continuing c. **Biologic males with osteoporosis or who are under 50 years of age and have experienced a low trauma fractures:** osteoporosis or low trauma fracture therapy is continuing If **ALL** criteria are met, then the request can be approved for the appropriate duration for the indicated treatment: • **Primary hypogonadism:** approve 12 months • **Secondary hypogonadism:** approve 12 months • **Biologic males with severely low testosterone who are symptomatic:** approve 12 months • **HIV-associated weight loss:** approve 6 months • **Chronic, high-dose glucocorticoid-therapy:** approve up to the duration of the expected regimen of chronic, high-dose glucocorticoid-therapy with a maximum duration of 12 months. • **Biologic males with osteoporosis or who are under 50 years of age and have experienced a low trauma fractures:** approve 12 months
Clinical Criteria	
Testosterone for treatment of delayed puberty	Testosterone may be considered medically necessary when patients meet **ALL** of the following criteria: 1. Patient is male and 14 years of age or older; **AND** 2. Patient has received the diagnosis of delayed puberty that is **NOT** secondary to a pathological cause; **AND** 3. Family history of delayed puberty has been evaluated to support differential diagnosis of delayed puberty; **AND** 4. Labs of recent serum LH, FSH, and testosterone are provided; **AND** 5. Patient must not have responded to "watchful waiting" with reassurance and psychological support in the previous 6 months a. Non-response of "watchful waiting" may be demonstrated by psychological concerns about delayed puberty and that

	delayed puberty cannot be addressed by reassurance and psychological support alone 6. Patient meets **ALL** of the following criteria: a. Patient does not have **ANY** of the following contraindications to testosterone therapy: i. breast cancer or known or suspected prostate cancer ii. elevated hematocrit (>50%) iii. untreated severe obstructive sleep apnea iv. severe lower urinary tract symptoms v. uncontrolled or poorly-controlled heart failure b. Patient has not experienced a major cardiovascular event (e.g., myocardial infraction, stroke, acute coronary syndrome, etc.) in the previous 6 months c. Patient does not have uncontrolled or poorly-controlled benign prostate hyperplasia or is at a higher risk of prostate cancer (e.g., elevation of PSA after initiating TRT) If **ALL** criteria are met, then the request can be approved for 12 months
	Criteria (Reauthorization) Testosterone may be approved for reauthorization when **ALL** of the following are met: 1. Puberty has not been completed in the patient; **AND** 2. Patient is unable to sustain a normal serum testosterone concentration when not receiving testosterone therapy
Clinical Criteria	
Testosterone for use in metastatic breast cancer	Testosterone may be considered medically necessary when patients meet **ALL** of the following criteria: 1. Patient is biologically female and 18 years of age or older; **AND** 2. Patient has received a diagnosis of advancing, inoperable metastatic breast cancer; **AND** 3. Patient has been postmenopausal for 1 to 5 years **OR** is premenopausal and has demonstrated benefit from oophorectomy and has a hormone-responsive tumor; **AND** 4. Documentation of first-line treatments used for metastatic breast cancer and information on treatment failures with first-line agents; **AND** 5. Drug is prescribed by or in consultation with an oncologist or a physician specializing in the treatment of metastatic breast cancer; **AND** 6. Patient does not have **ANY** of the following contraindications to testosterone therapy: a. elevated hematocrit (>50%) b. untreated severe obstructive sleep apnea

	c. severe lower urinary tract symptoms d. uncontrolled or poorly-controlled heart failure e. pregnant or may become pregnant *f.* major cardiovascular event (e.g., myocardial infraction, stroke, acute coronary syndrome, etc.) in the previous 6 months If **ALL** criteria are met, then the request can be approved for 12 months
	Criteria (Reauthorization)
	Testosterone may be approved for reauthorization when **ALL** of the following are met: 1. Patient continues to meet criteria 6 above; **AND** 2. Patient has not experienced any severe adverse events related to testosterone therapy

Table 1

Dosage and quantity limits

Name	Dosage Form	Strength	Quantity Level Limit
Androderm	transdermal patch	2mg	#30 patches per 30-days
		4mg	#30 patches per 30-days
AndroGel / generic	gel packet (2.5g)	1%	300g (4x75g) per 30-days
	gel packet (5g)	1%	300g (2x150g) per 30-days
	gel pump	1%	300g (4x75g) per 30-days
AndroGel / generic	gel packet (1.25g)	1.62%	37.5g (30 packets) per 30-days
	gel packet (2.5g)	1.62%	150g (60 packets) per 30-days
	gel pump	1.62%	150g (2x75g) per 30-days
Aveed	injectable solution	250mg/mL	750mg per 30-days
generic	topical solution	30mg/1.5mL	180mL (2x90mL) per 30-days
Fortesta / generic	gel	2%	120g (2x60g) per 30-days
Jatenzo	oral capsules	158mg	#60 capsules per 30-days
		198mg	#60 capsules per 30-days
		237mg	#60 capsules per 30-days
Striant	buccal system	30mg	#60 buccal systems per 30-days
Testim	gel	1%	300g (60x5g) per 30-days
Vogelxo / generic	gel packet	1%	300g (4x75g) per 30-days
	gel pump	1%	300g (60x5g) per 30-days
Testopel	pellets (implant)	75mg	6 pellets every 3 months
Depo-Testosterone / generic (cypionate)	injectable solution	100mg/mL	400mg per 28-days
		200mg/mL	400mg per 28-days
Methitest (methyltestosterone)	oral	10mg	#150 tablets per 30-days

methyltestosterone	oral	10 mg	#150 capsules per 30-days
Xyosted (enanthate)	Solution auto-injector	50mg/0.5mL	200mg per 28-days
		75mg/0.5mL	300mg per 28-days
		100ng/0.5mL	400mg per 28-days

Coding:

HCPCS Code	Description
J3121	Injection, testosterone enanthate, 1mg
J1071	Injection, testosterone cypionate, 1 mg

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20. Hembree, Wylie C, et al. "Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline." The Journal of clinical endocrinology and metabolism 94.9 (2009):3132-3154.
21. Product Information: XYOSTED(TM) subcutaneous injection, testosterone enanthate subcutaneous injection. Antares Pharma Inc (per FDA), Ewing, NJ, 2018

History

Date	Action and Summary of Changes
02/03/2020	Added Testopel, updated transgender health criteria
10/03/2019	Edited Note
06/21/2019	Reformatted clinical criteria sections; updated clinical documentation required for initial authorization and reauthorization
11/02/2018	Add Xyosted
04/20/2016	New Policy

Washington State Health Care Authority

Testosterone

***For treatment of gender dysphoria,** see the Transgender Health Services section of the Physician-Related Services/Health Care Professional Services Billing Guide.

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. **Without this information, we may deny the request in seven (7) working days.**

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Indicate the diagnosis for your patient (check all that apply):
   - ☐ Late-onset (age-related) hypogonadism
   - ☐ HIV-associated weight loss
   - ☐ Delayed puberty
   - ☐ Primary hypogonadism
     - Due to: ☐ Bilateral torsion ☐ Cryptorchidism ☐ Chemotherapy ☐ Klinefelter Syndrome ☐ Orchiectomy ☐ Orchitis ☐ Trauma or toxic damage from alcohol or heavy metals ☐ Vanishing testis syndrome
   - ☐ Secondary hypogonadism
     - Select: ☐ Idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency ☐ Pituitary-hypothalamic injury from tumors or radiation
   - ☐ Other. Specify:
   - ☐ Chronic high-dose glucocorticoid therapy
   - ☐ Osteoporosis/low trauma fracture. Provide T-score:
   - ☐ Metastatic breast cancer
2. If HIV-associated weight loss, provide the following for your patient:
   Actual body weight: Ideal body weight: Target body weight goal:
   Describe any changes in their weight during the last 6 months:
3. If chronic high-dose glucocorticoid therapy, provide the following for your patient:
   Diagnosis requiring glucocorticoid regimen:
   Current glucocorticoid regimen: Expected duration of treatment:
4. Provide your patient's two morning tests (between 8am to 10am) at least one week apart but no more than three months apart, demonstrating low testosterone levels (not applicable for diagnosis of metastatic breast cancer):
   Total serum testosterone level: ng/dL Total serum testosterone level: ng/dL
   Free testosterone level: pg/mL Free testosterone level: pg/mL
   Date taken: Date taken:
5. Provide your patient's follicle stimulating hormone (FSH) and luteinizing hormone (LH) levels at time of diagnosis (not applicable for diagnosis of metastatic breast cancer): FSH: _____ LH: _____
6. Indicate any of the following for your patient:

Breast cancer or known/suspected prostate cancer	☐ Yes	☐ No
Significant decrease in bone or muscle mass in the last 6 months	☐ Yes	☐ No
Uncontrolled/poorly controlled benign prostate hyperplasia	☐ Yes	☐ No
At higher risk of prostate cancer	☐ Yes	☐ No
Experienced a major cardiovascular event in the past six months	☐ Yes	☐ No
Uncontrolled or poorly-controlled heart failure	☐ Yes	☐ No
Elevated hematocrit (>50%)	☐ Yes	☐ No
Untreated severe obstructive sleep apnea (OSA)	☐ Yes	☐ No
Severe lower urinary tract symptoms	☐ Yes	☐ No
Receiving treatment for osteoporosis or low trauma fracture	☐ Yes	☐ No
Severe adverse events related to testosterone therapy	☐ Yes	☐ No
Pregnant or may become pregnant	☐ Yes	☐ No

Supporting documentation required:
Laboratory and testing results and chart notes documenting diagnosis.

Prescriber signature	Prescriber specialty	Date