A Public Entity
Inland Empire Health Plan

Drug Class Prior Authorization Criteria
Testosterone Hormone Replacement

Line of Business: Medicaid
P & T Approval Date: February 19, 2020 **Effective Date:** April 1, 2020

This policy has been developed through review of medical literature, consideration of medical necessity, generally accepted medical practice standards, and approved by the IEHP Pharmacy and Therapeutics Subcommittee.

Formulary Drugs Requiring Prior Authorization Review: Testosterone 12.5 mg/1.25 gm pump (generic **Vogelxo 1% pump**), Testosterone 25 mg/2.5 gm packet (generic **Androgel 1% packet**), Testosterone 50 mg/5 gm packet (generic **Androgel 1%** or **Vogelxo gel packet**)

CRITERIA:

TESTOSTERONE 12.5 MG/1.25 GM PUMP (GENERIC **VOGELXO PUMP**), TESTOSTERONE 25 MG/2.5 GM PACKET (GENERIC **ANDROGEL 1% PACKET**), TESTOSTERONE 50 MG/5 GM PACKET (GENERIC **ANDROGEL 1%** OR **VOGELXO GEL PACKET**)

Covered Uses:	Hypogonadism
Exclusion Criteria:	N/A
Required Medical Information:	Must meet the following requirement: a. Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit.
Age Restriction:	N/A
Prescriber Restrictions:	N/A
Other Criteria:	Re-authorization Criteria: Must meet "1" of the following requirements: a. Serum testosterone level within or below normal limits of the reporting lab. b. Documentation of dose adjustments and a serum testosterone level within normal limits.

Covered Uses:	Treatment of HIV-associated Hypogonadism
Exclusion Criteria:	N/A
Required Medical Information:	Must meet the following requirement: a. Documented pretreatment total testosterone levels less than the median age-adjusted testosterone levels or less than the laboratory's lower reference limit.
Age Restriction:	N/A
Prescriber Restrictions:	HIV Specialist or Infectious Disease Specialist
Other Criteria:	Re-authorization Criteria: Must meet the following requirement: a. Documented clinical response (e.g. improvement in weight, lean body mass) within the past 6 months (180 days).

Covered Uses:	Transgender Hormonal Treatment
Exclusion Criteria:	N/A
Required Medical Information:	Please refer to Transgender Hormonal Treatment Pediatric Policy and Transgender Hormonal Treatment Adult Policy.
Age Restriction:	N/A
Prescriber Restrictions:	N/A
Other Criteria:	N/A

Change Control		
Date	**Change**	**RPH**
02/19/2020	• Renew with no changes	ND
02/20/2019	• Updated format • Add to FY: testosterone enanthate • Add to FY with PA: Testosterone 12.5 mg/1.25 gm pump (generic **Vogelxo pump**), Testosterone 25 mg/2.5 gm packet (generic **Androgel 1% packet**), Testosterone 50 mg/5 gm packet (generic **Androgel 1%** or **Vogelxo gel packet**) • Remove criteria for **Androderm** patch (testosterone transdermal system), **Androgel gel 1.62%** (testosterone 1.62% gel), **Aveed** (testosterone undecanoate oil injectable), **Axiron** (testosterone topical solution), **Fortesta** (testosterone topical gel), **Natesto** (testosterone intranasal), **Striant** (testosterone buccal), **Testim** (testosterone topical gel), **Testopel** (testosterone pellets), **Vogelxo 1% gel** (testosterone gel), Testosterone cypionate kit. Non-formulary criteria will apply.	ND
06/29/2018	• Changed Format	IK
02/21/2018	• Renewed with no new changes/updates.	CT