Pharmacy Drug Policy Checklist

POLICY NAME	Testosterone, Implantable, Topical, Oral, and	POLICY #	1817P

Criteria

Topical, Oral, and Nasal Administration

- ☐ **1.1** Individual is male
- ☐ **1.2** Initial therapy ordered by an endocrinologist (hormone doctor) or urologist (urinary tract doctor)
- ☐ **1.3** Documentation of at least two clinically important sign and symptom of androgen deficiency (see Definition 3) as defined by the Endocrine Society Guidelines (2018)
- ☐ **1.4** Two consecutive fasting lab results taken in the morning, on two different occasions within the previous

Implantable Testosterone (e.g., Testopel Pellets)

- ☐ **2.1** Individual is male
- ☐ **2.2** Initial therapy ordered by an endocrinologist (hormone doctor) or urologist (urinary tract doctor)
- ☐ **2.3** Documentation of at least two clinically important signs and symptoms of androgen deficiency (see Definition 3) as defined by the Endocrine Society Guidelines (2018)
- ☐ **2.4** Two consecutive fasting lab results taken in the morning, on two different occasions within the previous

Coverage for Gender Incongruence (Illinois fully-insured and select Illinois self-funded plans)

- ☐ **3.1** Prior authorization is prohibited per section 356z.60 of the Illinois Insurance code
- ☐ **3.2** The health plan has measures in place to allow for claims to process at $0 cost share without prior authorization being required
- ☐ **3.3** For further questions, please contact the plan

Coverage for Gender Incongruence (all other members)

- ☐ **4.1** Documented diagnosis of gender incongruence (defined as a person with a discrepancy between their gender identity and gender assigned at birth)
- ☐ **4.2** Individual intending to have more “male” characteristics
- ☐ **4.3** Individual is past puberty
- ☐ **4.4** Testosterone pellets (Testopel) are covered under the medical benefit only
- ☐ **4.5** Authorization: 12 months

Exclusion Criteria – Any of the following prevents coverage

- ☐ **5.1** Members who are new starts to therapy with uncontrolled hypothyroidism must provide documentation that they are adequately treated prior to coverage of drugs for the treatment of hypogonadism
- ☐ **5.2** Testosterone therapy is not recommended in men planning fertility in the near term or in men with breast or prostate cancer, a palpable prostate nodule or induration, elevated hematocrit, untreated severe References obstructive sleep apnea, severe lower urinary tract symptoms, uncontrolled heart failure, myocardial infarction or stroke within the last 6 months, or thrombophilia
- ☐ **5.3** Testosterone replacement therapy is considered experimental, investigational/or unproven in all other situations in which the above criteria are not met, including but not limited to men with low testosterone levels in the absence of clinical signs and symptoms of hypogonadism; hormone replacement therapy for female menopause; delayed puberty in females
- ☐ **5.4** Based on the Endocrine Society Guidelines (2010) the recommended goal treatment range is between

and 700 ng/dl. Requests for quantities of medication which previously resulted in a fasting serum testosterone level > 700 ng/dl are not covered

- ☐ **5.5** Patients with newly diagnosed secondary hypogonadism without an identified underlying medical condition
- ☐ **5.6** Patients with secondary hypogonadism with low total testosterone levels and normal free testosterone levels CPT Codes