**Endocrine Agents: Androgens**

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| Criteria 1 | NP Agents – Jatenzo (AR), Methyltestosterone (AR), Natesto (AR), Testopel (AR), Testosterone Cypionate (AR), Testosterone Gel 1.62%, 2% (AR), Testosterone Sol 30mg/ACT (AR), Tlando (AR), Xyosted (AR) |
| Criteria 2 | P Agents  - Androderm (AR, PA), Testosterone Gel 1% (AR, PA), Testosterone Gel 1% Pump (AR, PA) |

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| **Criteria Title** | Endocrine Agents: Androgens | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| JATENZO | 079611 | GCNSeqNo |
| JATENZO | 079619 | GCNSeqNo |
| JATENZO | 079620 | GCNSeqNo |
| METHYLTESTOSTERONE | 003161 | GCNSeqNo |
| METHYLTESTOSTERONE | 003163 | GCNSeqNo |
| NATESTO | 073643 | GCNSeqNo |
| TESTOPEL | 019153 | GCNSeqNo |
| TESTOSTERONE CYPIONATE | 003147 | GCNSeqNo |
| TESTOSTERONE CYPIONATE | 003148 | GCNSeqNo |
| TESTOSTERONE GEL 1.62%, 2% | 067366 | GCNSeqNo |
| TESTOSTERONE GEL 1.62%, 2% | 070128 | GCNSeqNo |
| TESTOSTERONE GEL 1.62%, 2% | 070129 | GCNSeqNo |
| TESTOSERONE SOL 30 MG/ACT | 067154 | GCNSeqNo |
| TLANDO | 083222 | GCNSeqNo |
| XYOSTED | 079083 | GCNSeqNo |
| XYOSTED | 079085 | GCNSeqNo |
| XYOSTED | 079087 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0998 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 3 | 0999 |  | Select and Free Text | Has the provider submitted documentation of lab work to support the need for testosterone supplementation?  If yes, please submit documentation. | Y | 1000 |
| N | 1235 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 90 days with ALL preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 5 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 6 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | 1004 |
| 7 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1004 |
| N | 1235 |
| 8 | 1004 |  | Select | Is the patient younger than 18 years? | Y | 1235 |
| N | END (Pending Manual Review) |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., testosterone and hematocrit)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

 LENGTH OF AUTHORIZATIONS: 365 Days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |

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| **Criteria Title** | Endocrine Agents: Androgens | | |
| **Criteria Subtitle** | Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| ANDRODERM | 021606 | GCNSeqNo |
| ANDRODERM | 068099 | GCNSeqNo |
| TESTOSTERONE GEL 1% | 045215 | GCNSeqNo |
| TESTOSTERONE GEL 1% | 045216 | GCNSeqNo |
| TESTOSTERONE GEL 1% PUMP | 057874 | GCNSeqNo |
| TESTOSTERONE GEL 1% PUMP | 061294 | GCNSeqNo |
| TESTOSTERONE GEL 1% PUMP | 062542 | GCNSeqNo |

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| N | 1235 |
| 3 | 0999 |  | Select and Free Text | Has the provider submitted documentation of lab work to support the need for testosterone supplementation?  If yes, please submit documentation. | Y | 1000 |
| N | 1235 |
| 4 | 1000 |  | Select | Is the patient younger than 18 years? | Y | 1235 |
| N | END (Pending Manual Review) |
| 5 | 1234 |  | Select and Free Text | Has the provider submitted documentation of patient’s clinical response to treatment and ongoing safety monitoring (i.e., testosterone and hematocrit)? | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS:  365 Days

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| **Last Approved** | 4/20/2023 |
| **Other** |  |