MEDICAL MUTUAL®

Drug Policy

Policy:	**Testosterone Topical and Oral**	**Annual Review Date:** **11/21/2024**
Impacted Drugs:	**Androderm patch** **Android, Methitest, Testred (methyltestosterone oral)** **Androxy (fluoxymesterone oral)** **Axiron (testosterone topical solution)** **Fortesta (testosterone 2% topical gel)** **Jatenzo (testosterone undecanoate capsules)** **Natesto (testosterone nasal gel)** **Striant (testosterone buccal system)** **Testosterone 1% gel** **Testosterone 1.62% gel** **Testosterone transdermal solution** **Testosterone (generic oral formulations)** **Tlando (testosterone undecanoate capsules)** **Undecatrex (testosterone undecanoate capsules)** **Vogelxo (testosterone 1% gel)**	**Last Revised Date:** **11/21/2024**

OVERVIEW

Several testosterone (topical and nasal) products are available. This policy involves the use of the following products: Androderm patch, Android, Methitest, Testred, Androxy, Axiron (generic), Fortesta, Jatenzo, Natesto, Striant, Tlando, Undecatrex, Vogelxo, and generic testosterone oral and topical formulations.

The oral, topical (including nasal), and testosterone replacement products are all indicated for testosterone replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone. The prescribing information for the FDA-approved products define those patients and/or conditions for which use of testosterone replacement products is indicated:

- Primary hypogonadism (congenital or acquired) – testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone concentrations accompanied by gonadotropins (follicle-stimulating hormone [FSH], luteinizing hormone [LH]) above the normal range.
- Hypogonadotropic hypogonadism [congenital or acquired] –gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low testosterone serum concentrations, but have gonadotropins in the normal or low range.

The limitations of use for these products may include that safety and efficacy in men with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established; safety and efficacy in males < 18 years of age have not been established; and topical testosterone products may have different doses, strengths or application instructions that may result in different systemic exposure. The most recently labeled product Jatenzo is specifically contraindicated in men with hypogonadal conditions, such as "age-related hypogonadism", that are not associated with structural or genetic etiologies. The diagnosis of male hypogonadism is based on both signs/symptoms and low testosterone levels. By restoring normal levels of testosterone, the replacement regimens correct symptoms of hypogonadism, which can include malaise, loss of muscle strength, depressed mood, and decreased libido.

POLICY STATEMENT

This policy involves the use of testosterone oral and topical formulations. Prior authorization is recommended for pharmacy benefit coverage of testosterone oral, and topical formulations. Approval is recommended for those who meet the conditions of coverage in the **Criteria and Initial/Extended Approval** for the diagnosis provided. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with testosterone oral and topical formulations, as well as the monitoring required for adverse events and long-term efficacy, initial approval requires testosterone oral and topical formulations be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below. Injectable Testosterone products are evaluated based on the criteria found in the "Testosterone Injection and Pellet" policy.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of testosterone oral or topical formulations are recommended in those who meet the following criteria:

1. **Hypogonadism (Primary or Secondary) in Males* [Testicular Hypofunction/Low Testosterone with Symptoms]**

   Criteria. *Patient must meet the following criteria (A or B):*

   A. Initial Therapy:

   NOTE: the pre-treatment timeframe refers to signs and symptoms of androgen deficiency and serum testosterone levels prior to the initiation of any testosterone therapy.

   a. The patient has had persistent signs and symptoms (for example, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido) of androgen deficiency (pre-treatment); AND

   b. The patient has had two pre-treatment serum testosterone measurements, each taken in the morning on two separate days AND both levels were low, as defined by the normal laboratory reference values; AND

c. If the request is for Axiron, Natesto, Fortesta, Striant, or Vogelxo, the prescriber is verifying that the patient has tried one of the following: testosterone topical solution OR testosterone gel (generic products).

B. Continuation of therapy:
NOTE: the pre-treatment timeframe refers to signs and symptoms of androgen deficiency and serum testosterone levels prior to the initiation of any testosterone therapy.
   a. The patient has had persistent signs and symptoms (for example, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido) of androgen deficiency (pre-treatment); AND
   b. The patient has had at least one total serum testosterone level within the last 6 months within or below the normal limits of the reporting lab OR one total serum testosterone level beyond the normal limits, but the dose has been adjusted is required. AND
   c. If the request is for Axiron, Natesto, Fortesta, Striant, or Vogelxo, the prescriber is verifying that the patient has tried one of the following: testosterone topical solution OR testosterone gel (generic products).

*Males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression.

OTHER USES WITH SUPPORTIVE EVIDENCE

2. <u>Female-to-Male (FTM) Gender Reassignment (i.e., Endocrinologic Masculinization, Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Female-To-Male (FTM) Gender Reassignment)</u>
Criteria. *Approve for 365 days if the requested medication is being prescribed by, or in consultation with, an endocrinologist or a physician who specializes in the treatment of transgender patients.*

Initial Approval/ Extended Approval.
A) *Initial Approval:* 1 year
B) *Extended Approval:* 2 years

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Oral, topical, and nasal testosterone products (e.g., Jatenzo, Androderm, Axiron, Fortesta, Natesto, Striant, Vogelxo) have not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. Rationale for non-coverage for these specific conditions is provided below. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval.)

1. **To Enhance Athletic Performance.** Topical testosterone products are not recommended for approval because this indication is excluded from coverage in a typical pharmacy benefit.

2. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

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