Pharmacy Management Drug Policy

SUBJECT: Testosterone (Testopel, Aveed, Azmiro) Policy
POLICY NUMBER: PHARMACY-132
EFFECTIVE DATE: 07/2025
LAST REVIEW DATE: 07/01/2025

If the Patient's subscriber contract excludes coverage for a specific service or prescription drug, it is not covered under that contract. In such cases, medical or drug policy criteria are not applied. This drug policy applies to the following line/s of business:

Policy Application

Category:	☒ Commercial Group (e.g., EPO, HMO, POS, PPO)	☒ Medicare Advantage
	☒ On Exchange Qualified Health Plans (QHP)	☐ Medicare Part D
	☒ Off Exchange Direct Pay	☒ Essential Plan (EP)
	☒ Medicaid & Health and Recovery Plans (MMC/HARP)	☒ Child Health Plus (CHP)
	☐ Federal Employee Program (FEP)	☐ Ancillary Services
	☒ Dual Eligible Special Needs Plan (D-SNP)	

DESCRIPTION:

Testosterone is an androgen hormone responsible for normal growth and development of male sex characteristics. Endogenous testosterone is synthesized by cells in the testes, ovaries, and the adrenal cortex. Therapeutically, testosterone is used in the management of primary or acquired hypogonadism in males (adolescent or adult), and use is also appropriate for selected adolescent males with constitutional delay of growth and puberty. In prepubertal males with hypogonadism, testosterone treatment is directed at initiating pubertal development at the appropriate age, then maintaining virilization. Per guidelines, adult men with low testosterone concentrations due to medical conditions, and not exclusively due to aging, are appropriate candidates for testosterone replacement therapy if certain criteria are met.

The Endocrine Society recommends offering testosterone therapy to patients with symptoms of testosterone deficiency and consistently and unequivocally low morning testosterone concentrations. In men >65 years of age, treatment should only be initiated on an individual basis and after consultation with the patient regarding risks and benefits, as safety and efficacy in men with age-related hypogonadism (or late-onset hypogonadism) has not been established.

This policy applies to the injectable testosterone preparations of Aveed (intramuscular injection), Azmiro (intramuscular injection as prefilled syringe) and Testopel (pellets for subcutaneous implantation). Due to the lack of head-to-head studies assessing comparative efficacy between injectable testosterone formulations, request for Aveed, Azmiro or Testopel will require trials of cost-effective testosterone cypionate or testosterone enanthate injections with severe adverse effects or suboptimal therapeutic effects.

POLICY:

Requests for Aveed, Azmiro or Testopel as hormone replacement therapy may be approved if the following criteria are met:

A. For the treatment **Primary or Secondary Hypogonadism**

1. Patient must be at least 18 years of age **AND**
2. Patient was assigned male at birth **AND**
3. Patient must have tried at least 3 months of testosterone cypionate or testosterone enanthate with severe side effects or suboptimal therapeutic effects **AND**
4. Must be prescribed by or in consultation with an endocrinologist, oncologist, or urologist **AND**
5. Documentation is provided that prior to starting testosterone therapy, an initial and a repeat (at least 24 hours apart) morning total testosterone level is provided to confirm a low testosterone serum level indicating one of the following: **(a or b)**
    a. Patient is 70 years of age or younger with a serum testosterone level of less than 300 ng/dL; **OR**
    b. Patient is over 70 years of age with a serum testosterone level of less than 200 ng/dL; **AND**
6. Patient has ***one*** of the following conditions: **(a or b)**
    a. Primary hypogonadism (congenital or acquired) (for example, bilateral torsion, cryptorchidism, chemotherapy, Klinefelter Syndrome, orchiectomy) **OR**
    b. Hypogonadotropic hypogonadism (also known as secondary hypogonadism) (congenital or acquired) (for example, gonadotropic or luteinizing hormone-releasing hormone deficiency, pituitary-hypothalamic injury); **AND**
7. Patient presents with symptoms associated with hypogonadism, such as, but not limited to at least **one** of the following (a through i):
    a. Reduced sexual desire (libido) and activity
    b. Decreased spontaneous erections
    c. Breast discomfort/gynecomastia
    d. Loss of body (axillary and pubic) hair, reduced need for shaving
    e. Very small (especially less than 5 mL) or shrinking testes
    f. Inability to father children or low/zero sperm count
    g. Height loss, low trauma fracture, low bone mineral density
    h. Hot flushes, sweats
    i. Other less specific signs and symptoms including decreased energy, depressed mood/dysthymia, irritability, sleep disturbance, poor concentration/memory, diminished physical or work performance
8. Approved dosage:
    a. Testopel: 150 to 450 mg subcutaneous implantation every 3 to 6 months.
    Note: The number of pellets to be implanted depends upon the minimal daily requirements of testosterone propionate determined by a gradual reduction of the amount administered parenterally. The usual dosage is as follows: implant two 75 mg pellets for each 25 mg testosterone propionate required weekly.
    b. Aveed: The recommended dose is 3 mL (750 mg) injected intramuscularly, followed by 3 mL (750 mg) injected after 4 weeks, then 3 mL (750 mg) injected every 10 weeks thereafter.
    c. Azmiro: The recommended dosage is 50mg to 400mg administered every 2 to 4 weeks intramuscularly

9. Coverage Duration
    a. Initial coverage will be granted for one year
    b. Recertification (continuation) is two years if documentation of ongoing clinical benefit is provided (e.g., therapeutic testosterone lab levels, adequate symptom control, or disease stability)
    c. After 2 years of continuous therapy without documentation of clinical benefits, the provider must submit a letter of medical necessity describing the ongoing need

B. For the treatment of **Delayed Male Puberty**

1. Patient must be at least 14 years of age and was assigned male at birth **AND**
2. Patient must have a confirmed diagnosis, supported by clinical or laboratory evidence, of delayed male puberty (defined as the absence of testicular enlargement [testicular volume less than 4 milliliters [mL] or Tanner stage 1]) by age 14
3. Coverage Duration
    a. Initial coverage will be granted for six months
    b. Recertification (continuation) is three months if a letter of medical necessity describing the ongoing need is provided

C. For the initial treatment of **Gender Dysphoria**

1. Medicaid Managed Care Plan (MMCP) and Health and Recovery Plan (HARP) criteria:

    In accordance with the revised regulations, Medicaid FFS and MMC plans will provide reimbursement for medically necessary hormone therapy for treatment of gender dysphoria. Hormone therapy, whether or not in preparation for gender reassignment surgery, will be covered as follows:

    I. Treatment with gonadotropin-releasing hormone agents (pubertal suppressants), based upon a determination by a qualified medical professional that an individual is eligible and ready for such treatment, i.e., that the individual:
        a. Meets the criteria for a diagnosis of gender dysphoria
        b. Has experienced puberty to at least Tanner stage 2, and pubertal changes have resulted in an increase in gender dysphoria
        c. Does not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment
        d. Has adequate psychological and social support during treatment; and
        e. Demonstrates knowledge and understanding of the expected outcomes of treatment with pubertal suppressants and cross-sex hormones, as well as the medical and social risks and benefits of sex reassignment.
    II. Treatment with cross-sex hormones for patients who are 16 years of age or older, based upon a determination of medical necessity made by a qualified professional; patients who are under 18 years of age must meet the applicable criteria listed in paragraph 1 above. Payment for cross-sex hormones treatment for a patient who is under 16 years of age and who otherwise meets these requirements will be made in specific cases if medical necessity is demonstrated by a qualified medical professional and prior approval is received.
    III. New York State (NYS) Medicaid reimbursement is only available for medically necessary cross-sex hormones that are Federal Drug Administration (FDA) approved or Compendia supported for the treatment of gender dysphoria exclusively include:

conjugated estrogens, estradiol, testosterone cypionate, and testosterone topical gel 1.62 percent. The official Compendia sources would include American Hospital Formulary Service (AHFS) and Micromedex Drug Dex. [Referred to Medical Policy Number: 7.01.105]

2. Commercial Plan criteria:
   I. Must have a diagnosis of Gender Dysphoria that meets the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) criteria for Gender Dysphoria **AND**
   II. The diagnosis must be confirmed by an experienced mental health professional **AND**
   III. The patient must be an adolescent that has reached tanner stage 2 of puberty

3. Coverage duration is two years at a time

EXCLUSION CRITERIA:

As the effectiveness for indications other than the ones listed above has not been established, Testopel, Aveed and Azmiro are considered experimental, investigational, or unproven, including but not limiting to the following list:

1. Idiopathic hypogonadism (not due to primary or secondary hypogonadism as defined above)
2. Menopause (female or male)
3. Pain management in women
4. Female sexual dysfunction/hypoactive sexual desire disorder
5. Improvement of cognitive function in aging men
6. Treatment of cancers (e.g., breast, kidney, and prostate)

POLICY GUIDELINES:

1. Prior-authorization is contract dependent.
2. Not all contracts cover all Medical Infusible drugs. Refer to specific contract/benefit plan language for exclusions of Injectable Medications.
3. This policy does not apply to Medicare Part D and D-SNP pharmacy benefits. The drugs in this policy may apply to all other lines of business including Medicare Advantage.
4. For Patients with Medicare Advantage, medications with a National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) will be covered pursuant to the criteria outlined by the NCD and/or LCD. NCDs/LCDs for applicable medications can be found on the CMS website at https://www.cms.gov/medicare-coverage-database/search.aspx. Indications that have not been addressed by the applicable medication's LCD/NCD will be covered in accordance with criteria determined by the Health Plan (which may include review per the Health Plan's Off-Label Use of FDA Approved Drugs policy). Step therapy requirements may be imposed in addition to LCD/NCD requirements.
5. For Medicare Advantage plans, the preferred product requirement only applies to patients who are new to therapy and will not affect patients who are currently established on therapy with non-preferred product
6. Continued approval at time of recertification will require documentation that the drug is providing ongoing benefit to the patient in terms of improvement or stability in disease state or condition. Such documentation may include progress notes, imaging or laboratory findings, and other objective or subjective measures of benefit which support that continued use of the requested product is medically necessary. Also, ongoing use of the requested product must continue to reflect the current policy's preferred formulary. Recertification reviews may result in the

requirement to try more cost-effective treatment alternatives as they become available (i.e., generics, biosimilars, or other guideline-supported treatment options). Requested dosing must continue to be consistent with FDA-approved or off-label/guideline-supported dosing recommendations.

7. For contracts where Insurance Law § 4903(c-1), and Public Health Law § 4903(3-a) are applicable, if trial of preferred drug(s) is the only criterion that is not met for a given condition, and one of the following circumstances can be substantiated by the requesting provider, then trial of the preferred drug(s) will not be required. The provider must make their intent to override a trial of the preferred drugs clear and must provide rationale and supporting documentation for one of the following:
   - The required prescription drug(s) is (are) contraindicated or will likely cause an adverse reaction or physical or mental harm to the Patient;
   - The required prescription drug is expected to be ineffective based on the known clinical history and conditions and concurrent drug regimen;
   - The required prescription drug(s) was (were) previously tried while under the current or a previous health plan, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action was (were) previously tried and such prescription drug(s) was (were) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
   - The required prescription drug(s) is (are) not in the patient's best interest because it will likely cause a significant barrier to adherence to or compliance with the plan of care, will likely worsen a comorbid condition, or will likely decrease the ability to achieve or maintain reasonable functional ability in performing daily activities;
   - The individual is stable on the requested prescription drug. The medical profile of the individual (age, disease state, comorbidities), along with the rational for deeming stability as it relates to standard medical practice and evidence-based practice protocols for the disease state will be taken into consideration.
   - The above criteria are not applicable to requests for brand name medications that have an AB rated generic. We can require a trial of an AB-rated generic equivalent prior to providing coverage for the equivalent brand name prescription drug.

CODES:

Eligibility for reimbursement is based upon the benefits set forth in the Patient's subscriber contract. CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.
Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key:
Experimental/Investigational = (E/I),
Not medically necessary/ appropriate = (NMN).

HCPCS:

Preferred: J1071 (testosterone cypionate, Depo-Testosterone), J3121 testosterone enanthate
Non-preferred: S0189/J3490 (Testopel), J3145/C9023 (Aveed), J1072 Azmiro

UPDATES:

Date	Revision
07/01/2025	Revised
11/21/2024	P&T Committee Approval

REFERENCES:

1. Aveed Package Insert updated August 28, 2021
2. Azmiro Package Insert updated January 3, 2025
3. Testopel Package Insert updated March 28, 2024
4. Mulhall JP, Trost LW, Brannigan RE, et al. Evaluation and Management of Testosterone Deficiency: AUA Guideline. J Urol. 2018;200:423-432. Epub 2018 Mar 28.
5. Bhasin S, Brito JP, Cunningham GR, et al. Testosterone Therapy in Men With Hypogonadism: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2018;103:1715-1744.