MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Medical Policy
Topical Testosterone

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Policy Number: 345

BCBSA Reference Number: None

Related Policies

None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary and step status of the medications affected by this policy.

**Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and criteria below are met.

Drug	Formulary Information Standard Formulary Status
STEP 1	
Testosterone Gel 25 mg/2.5gm, 50mg/5gm Packets [FDA approved Generic], 50mg/5gm Gel, 30mg/1.5ml, 1.62% gel pump, 1.62% Gel packets, 10% gel pump	Covered
Androderm® (testosterone patch)	
STEP 2	
AndroGel® (testosterone gel)	Prior use of Step 1 Required
Axiron® (testosterone solution)	

Fortesta™** (testosterone gel)	
Natesto™** (testosterone gel)	
Testim®** (testosterone gel)	
Testosterone gel 50 mg/5 g (5 g)** (Authorized Brand of Testim®**) [Customarily referred to as an authorized Generic]	
Testosterone gel 12.5 mg/actuation (1%) (75 g)** & 50mg/5GM Gel Packet** (Authorized Brand of Vogelxo™**) [Customarily referred to as an authorized Generic]	
Vogelxo™** (testosterone gel)	

We may cover the Topical Testosterone medications listed in the chart above for new starts* in the following stepped approach.[1]

*New start is defined as no previous paid claim for the requested medication within the past 130 days

Step 1: Step 1 medications will be covered without prior authorization.

Step 2: Step 2 medications may be covered when **one** of the following criteria are met:

- There must be evidence of a BCBSMA paid claim by the patient of a step 1 medication within the previous 130 days.
  OR
- There must be evidence of a BCBSMA paid claim by the patient of a step 2 medication within the previous 130 days.

** Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and requires **TWO** formulary drugs to be tried prior to granting a Formulary Exception (FE).

Note:*Exception requests based exclusively on the use of samples will not meet coverage criteria for non-formulary medications. Additional clinical information demonstrating medical necessity of the non-formulary medication must be submitted by the requesting prescriber for review.

We do not cover drugs listed in the above chart unless the above step therapy criteria are met.

Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Prior Authorization Information

Outpatient

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **required**.

Policy History

Date	Action
7/2019	Updated to add Axiron (7/2018 was not coded) & Androgel to step 2.
2/2019	Updated to add Generic Androgel and a generic 10% gel pump to step 1.
9/2018	Updated to add a new Generic to step one and clarify Non-covered requirements.
1/2018	Updated to add generic Testosterone Soln and to move Axiron to step 2 of policy
6/2017	Updated address for Pharmacy Operations.
10/2015	Updated to add FDA approved Generic.
4/2015	Added Natesto™ to Step 2.
1/2015	Move Testim & its Authorized Generic to non-covered.
10/2014	Added AndroGel®, Androderm® & Axiron® to Step 1. Removed Step 3 and made policy a 2 step policy.
8/2014	Updated to include generics.
1/2014	Updated ExpressPAth Language and removed Blue Value.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
1/1/2012	New policy, effective 1/1/2012, describing covered and non-covered indications.

References

1. Androderm® [package insert]. Morristown, NJ: Watson Pharma, Inc.; 2010.
2. AndroGel® [package insert]. North Chicago, IL: Abbott Laboratories; 2011.
3. Axiron® [package insert]. Indianapolis, IN: Eli Lilly and Company ; 2011.
4. Fortesta™ [package insert]. Chadds Ford, PA: Endo Pharmaceuticals; 2011.
5. Testim® [package insert]. Malvem, PA: Auxilium Pharmaceuticals, Inc. 2009.
6. Vogelxo™ [package insert]. Maple Grove, MN: Upsher-Smith Laboratories, Inc; 2014
7. Naesto™ [package insert]. Malvern, PA: Endo Pharmaceuticals Inc ; 11/2014

Endnotes

1. Based on the recommendations of the BCBSMA Pharmacy and Therapeutics Committee meeting on 9/13/2011.

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf