Pharmacy Medical Policy

Topical Testosterone

Table of Contents

- Policy: Commercial
- Policy: Medicare
- Information Pertaining to All Policies
- Policy History
- References
- Endnotes
- Forms

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. Physicians may also submit requests for retail pharmacy exceptions via the web using Express PA which can be found on the BCBSMA provider portal or directly on the web at https://provider.express-path.com. 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.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Formulary Information</th>
<th>Standard</th>
<th>Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testosterone Gel</td>
<td>25 mg/2.5gm, 50mg/5gm Packets [FDA approved Generic], 50mg/5gm Gel, 30mg/1.5ml</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Androderm® (testosterone patch)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AndroGel® (testosterone gel)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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)** & 50 mg/5GM Gel Packet** (Authorized Brand of Vogelxo™)  
[Customarily referred to as an authorized Generic]  
Vogelxo™ (testosterone gel)  

Prior use of Step 1 Required

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

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

Managed Care Authorization Instructions

- Physicians may call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients who do not meet the step-therapy criteria at the point of sale.

Pharmacy Operations: (800) 366-7778
• Physicians may also fax or mail the attached form to the address above. The Formulary Exception/Prior Authorization form is included as part of this document for physicians to submit for patients who do not meet the step therapy criteria at the point of sale.

• Physicians may also submit requests for retail pharmacy exceptions via the web using Express Path which can be found on the BCBSMA provider portal or directly on the web at https://provider.express-path.com.

**PPO and Indemnity Authorization Instructions**

• Physicians may call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients who do not meet the step-therapy criteria at the point of sale. Pharmacy Operations: (800)366-7778

• Physicians may also fax or mail the attached form to the address above. The Formulary Exception/Prior Authorization form is included as part of this document for physicians to submit for patients who do not meet the step therapy criteria at the point of sale.

• Physicians may also submit requests for retail pharmacy exceptions via the web using Express Path which can be found on the BCBSMA provider portal or directly on the web at https://provider.express-path.com.

**Policy History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/2018</td>
<td>Updated to add a new Generic to step one and clarify Non-covered requirements.</td>
</tr>
<tr>
<td>1/2018</td>
<td>Updated to add generic Testosterone Soln and to move Axiron to step 2 of policy</td>
</tr>
<tr>
<td>6/2017</td>
<td>Updated address for Pharmacy Operations.</td>
</tr>
<tr>
<td>10/2015</td>
<td>Updated to add FDA approved Generic.</td>
</tr>
<tr>
<td>4/2015</td>
<td>Added Natesto™ to Step 2.</td>
</tr>
<tr>
<td>1/2015</td>
<td>Move Testim &amp; its Authorized Generic to non-covered.</td>
</tr>
<tr>
<td>10/2014</td>
<td>Added AndroGel®, Androderm® &amp; Axiron® to Step 1. Removed Step 3 and made policy a 2 step policy.</td>
</tr>
<tr>
<td>8/2014</td>
<td>Updated to include generics.</td>
</tr>
<tr>
<td>1/2014</td>
<td>Updated ExpressPAth Language and removed Blue Value.</td>
</tr>
<tr>
<td>4/2012</td>
<td>No changes to policy statements.</td>
</tr>
<tr>
<td>1/1/2012</td>
<td>New policy, effective 1/1/2012, describing covered and non-covered indications.</td>
</tr>
</tbody>
</table>

**References**


**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:**