

Clinical Policy: Testosterone (Androderm)

Reference Number: HIM.PA.87

Effective Date: 12.01.14

Last Review Date: 11.18

Line of Business: HIM

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Testosterone transdermal system (Androderm[®]) is a topical androgen.

FDA Approved Indication(s)

Androderm is indicated for replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone:

- Primary hypogonadism (congenital or acquired) - testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome, or orchiectomy
- Hypogonadotropic hypogonadism (congenital or acquired) - gonadotropic lutenizing hormone-releasing hormone deficiency, or pituitary - hypothalamic injury from tumors, trauma, or radiation

Limitation(s) of use:

- Safety and efficacy of Androderm in men with “age-related hypogonadism” (also referred to as “late-onset hypogonadism”) have not been established.
- Safety and efficacy of Androderm in males less than 18 years old have not been established.
- Topical testosterone products may have different doses, strengths, or application instructions that may result in different systemic exposure.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Androderm is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hypogonadism (must meet all):

1. Diagnosis of primary hypogonadism or hypogonadotropic hypogonadism;
2. Age \geq 18 years;
3. Documentation of serum testosterone level $<$ 300 ng/dL on at least 2 separate days within the last 6 months;
4. Failure* of testosterone cypionate or testosterone enanthate injection at up to maximally indicated dose unless contraindicated or clinically significant adverse effects are experienced;
**Failure is demonstrated by lower than normal total testosterone levels as compared to laboratory reference values*
5. Dose does not exceed 1 patch per day.

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace.

II. Continued Therapy

A. Hypogonadism (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 1 patch per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PHAR.21 for health insurance marketplace or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
testosterone cypionate	50 to 400 mg IM once every 2 to 4 weeks	400 mg every 2 to 4 weeks
testosterone enanthate injection	50 to 400 mg IM once every 2 to 4 weeks	400 mg every 2 to 4 weeks

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):

- Men with carcinoma of the breast or known or suspected carcinoma of the prostate
- Pregnant or breastfeeding women (testosterone may cause fetal harm)
- Boxed warning(s): none reported

Appendix D: General Information

- Per the Endocrine Society (2018), the diagnosis of hypogonadism requires unequivocally and consistently low testosterone levels on at least 2 separate mornings. Although the lower limit of normal for testosterone can vary depending on the laboratory used, clinical trials for a number of testosterone agents defined it as < 300 ng/dL. Additionally, the American Urological Association suggests < 300 ng/dL as a reasonable cut-off in support of low testosterone diagnosis (2018).
- Patients with primary hypogonadism usually have low serum testosterone concentrations and gonadotropins (follicle stimulating hormone and luteinizing hormone) above the normal range. Patients with hypogonadotropic hypogonadism have low serum testosterone concentrations but have gonadotropins in the normal or low range.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Hypogonadism	1 patch topically nightly for 24 hours	6 mg/day

VI. Product Availability

Transdermal system: 2 mg/day, 4 mg/day

VII. References

1. Androderm Prescribing Information. Irvine, CA: Allergan USA, Inc.; June 2018. Available at <https://www.androderm.com>. Accessed July 16, 2018.
2. Basin 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(5): 1715-1744. Available at: <https://academic.oup.com/jcem/article/103/5/1715/4939465>.
3. Mulhall JP, Trost LW, Brannigan RE, et al. Evaluation and management of testosterone deficiency AUA guideline. American Urological Association. Published 2018. Available at: [http://www.auanet.org/guidelines/testosterone-deficiency-\(2018\)](http://www.auanet.org/guidelines/testosterone-deficiency-(2018)). Accessed July 9, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Reformatted guideline to new format. Added Workflow reference document. Removed exclusion for use in gender reassignment transitioning	12.15	12.15
Removed gender restriction to male. Updated references.	11.16	11.16
Converted to new template. Added testosterone enanthate injection as a trial option.	04.17	08.17
3Q 2018 annual review: no significant changes; added age; references reviewed and updated.	06.17.18	08.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2018 annual review: added requirement for documentation of testosterone levels per PI and guidelines; references reviewed and updated.	07.16.18	11.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note:

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.

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