Effective date: 12/2017
Revised: 7/2018, 12/2019 Reviewed: 12/2017, 7/2018, 12/2019, 7/2020, 5/2021, 4/2022, 4/2023 Scope: Medicaid

Testosterone Transdermal Gel 1%

POLICY

I. CRITERIA FOR APPROVAL

A. Primary or hypogonadotropic hypogonadism

Authorization of 12 months may be granted when all the following criteria are met:

1. The requested formulary drug is being prescribed for primary or hypogonadotropic hypogonadism [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]
2. Patient meets either of the following criteria:
   a. Before the start of testosterone therapy, the patient has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values
   b. For continuation of testosterone therapy: before the patient started testosterone therapy, the patient had a confirmed low testosterone level according to current practice guidelines or your standard lab reference values
3. Patient has experienced an inadequate treatment response, intolerance or contraindication to formulary injectable testosterone (testosterone cypionate or testosterone enanthate)

B. Gender dysphoria

Authorization of 12 months may be granted when all of the following criteria are met:

1. The requested formulary drug is being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy
2. Patient has experienced an inadequate treatment response, intolerance or contraindication to formulary injectable testosterone (testosterone cypionate or testosterone enanthate)

II. QUANTITY LIMIT

1. Testosterone transdermal gel 50mg/5gm (1%) [GPI 23100030004030] – 300 gm / 30 days
2. Testosterone transdermal gel pump 12.5mg/act (1%) [GPI 23100030004040] – 150 gm / 30 days

III. REFERENCES

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