

UPMC Health Plan POLICY AND PROCEDURE MANUAL

POLICY NUMBER: RX-PA.009
REVISION DATE: 04/2008
ANNUAL APPROVAL DATE: 04/2008
PAGE NUMBER: 1 of 3

SUBJECT: Testosterone
INDEX TITLE: Clinical Pharmacy Services
ORIGINAL DATE: 11/15/01

This policy applies to the following lines of business: (Check those that apply.)

Commercial:					
HMO ()		POS ()		PPO ()	
Fully Insured ()		Self-funded/ASO ()		HSA ()	
Medicare Select ()		Medicare Supplement ()			
DPW-MA:					
Health Choices ()			Voluntary ()		All (X)
CMS-MA:					
HMO ()	PPO ()	Specialty Needs Plan ()	Part D ()	PFFS ()	All ()
PID-CHIP:					
Free ()			Sub ()		All (X)

I. POLICY

It is the policy of UPMC Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, as defined in CRM.015-Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.003-Prior Authorization Process.

Testosterone products are subject to the prior authorization process.

II. DEFINITIONS

N/A

III. PURPOSE

The purpose of this policy is to define the prior authorization process for Testosterone.

IV. SCOPE

This policy applies to the Pharmacy Services Department.

V.

PROCEDURE

Criteria for Testosterone

- UPMC Health Plan covers testosterone for use in men with conditions associated with a deficiency or absence of endogenous testosterone (repeated morning serum testosterone level < 300ng/dL). These conditions are:
 - Primary hypogonadism (congenital or acquired) – testicular failure due to cryptorchidism, bilateral torsions, orchitis, vanishing testis syndrome, or orchidectomy; or,
 - Hypogonadotropic hypogonadism (congenital or acquired) – idiopathic gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency, or pituitary-hypothalamic injury from tumors, trauma or radiation.
- Testosterone products will not be covered for female members. Please refer to RX.008.1 - Exceptions due to Medical Necessity - Medical Assistance and Children's Health Insurance Program and RX.008.2 - Exceptions due to Medical Necessity - Commercial.

Limitations

If a member does not meet the above approval criteria, the request will be referred to the UPMC Health Plan Medical Director for review.

Bibliography

1. Genitourinary Disorders; Male Reproductive Endocrinology: Male Hypogonadism. The Merck Manuals Online Medical Library: The Merck Manual for Healthcare Professionals, updated April 2007. Accessed 9/14/07 at <http://www.merck.com/mmpe/sec17/ch227/ch227b.html#sec17-ch227-ch227b-214>
2. Androderm Product Information. Watson Pharma, Inc. Corona, CA. June 2001.
3. Androgel Product Information. Unimed Pharmaceuticals, Inc. Marietta, GA. November 2002.
4. Delatestryl Product Information. Bristol-Myers Squibb. Princeton, NJ. October 1995.
5. Bremner WJ, Vitiello MV, Prinz PN. Loss of circadian rhythmicity in blood testosterone levels with ageing in normal men. *J Clin Endocrinol Metab.* 1983; 56:1278.