

Clinical Policy Title:	testosterone
Policy Number:	RxA.235
Drug(s) Applied:	Vogelxo®
Original Policy Date:	03/06/2020
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Hypogonadism (must meet all):

1. Diagnosis of primary hypogonadism or hypogonadotropic hypogonadism;
2. Documentation of serum testosterone level less than the lower end of the normal range of the assay used on at least 2 separate occasions within the last 6 months;
3. Trial and failure of generic testosterone gel, unless contraindicated or clinically significant adverse effects are experienced;

Approval duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Hypogonadism:

1. Member is currently receiving medication in the past 120 days that has been authorized by RxAdvance or the member has met the initial approval criteria.

Approval duration

All Lines of Business (except Medicare): 12 months

References

1. Basin S, Brito JP, Cunningham GR, et al. Testosterone therapy in men with hypogonadism: an endocrine society* clinical practice guideline. The Journal of Clinical Endocrinology & Metabolism. 2018;103(5):1715-1744. Available at: <https://academic.oup.com/jcem/article/103/5/1715/4939465>. Accessed March 20, 2025.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established	02/2020	03/06/2020
Policy was reviewed: <ol style="list-style-type: none"> 1. Policy description table updated. 2. Continuation therapy criteria II.A.1. rephrased to "Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy" 	07/29/2020	09/14/2020

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<ul style="list-style-type: none"> 3. Initial therapy and continued therapy approval duration updated. 4. References were updated. 		
Policy was reviewed: <ul style="list-style-type: none"> 1. References were reviewed and updated. 	03/31/2021	06/10/2021
Policy was reviewed: <ul style="list-style-type: none"> 1. References were reviewed and updated. 	01/05/2022	04/18/2022
Policy was reviewed: <ul style="list-style-type: none"> 1. References were reviewed and updated. 	12/29/2022	04/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed.	4/1/2024	4/1/2024
Policy was reviewed: <ul style="list-style-type: none"> 1. Updated Continuation of therapy Language. 2. References were reviewed and updated. 	03/20/2025	04/10/2025
Policy reviewed.	12/11/2025	12/11/2025