

# Initial Prior Authorization

## Testosterone – Testosterone Enanthate

### Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name	Dosage Form
testosterone enanthate (generic Delatestry – brand unavailable)	testosterone enanthate	injection
Xyosted	testosterone enanthate	injection

### Indications

#### FDA-approved Indications

##### Testosterone Enanthate Injection

###### Males

Testosterone enanthate injection (generic Delatestryl) is indicated for replacement therapy in conditions associated with a deficiency or absence of endogenous testosterone.

Primary hypogonadism (congenital or acquired) - Testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchiectomy.

Hypogonadotropic hypogonadism (congenital or acquired) - Gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation. (Appropriate adrenal cortical and thyroid hormone replacement therapy are still necessary, however, and are actually of primary importance).

If the above conditions occur prior to puberty, androgen replacement therapy will be needed during the adolescent years for development of secondary sexual characteristics. Prolonged androgen treatment will

be required to maintain sexual characteristics in these and other males who develop testosterone deficiency after puberty.

Safety and efficacy of testosterone enanthate injection (generic Delatestryl) in men with age-related hypogonadism have not been established.

Delayed puberty - Testosterone enanthate injection (generic Delatestryl) may be used to stimulate puberty in carefully selected males with clearly delayed puberty. These patients usually have a familial pattern of delayed puberty that is not secondary to a pathological disorder; puberty is expected to occur spontaneously at a relatively late date. Brief treatment with conservative doses may occasionally be justified in these patients if they do not respond to psychological support. The potential adverse effect on bone maturation should be discussed with the patient and parents prior to androgen administration. An X-ray of the hand and wrist to determine bone age should be obtained every six months to assess the effect of treatment on the epiphyseal centers.

## Females

Metastatic mammary cancer - Testosterone enanthate injection (generic Delatestryl) may be used secondarily in women with advancing inoperable metastatic (skeletal) mammary cancer who are one to five years postmenopausal. Primary goals of therapy in these women include ablation of the ovaries. Other methods of counteracting estrogen activity are adrenalectomy, hypophysectomy, and/or anti-estrogen therapy. This treatment has also been used in premenopausal women with breast cancer who have benefited from oophorectomy and are considered to have a hormone-responsive tumor. Judgment concerning androgen therapy should be made by an oncologist with expertise in this field.

## Xyosted

Xyosted (testosterone enanthate) injection is an androgen indicated for testosterone replacement therapy in adult 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 testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone concentrations and gonadotropins (follicle-stimulating hormone [FSH], luteinizing hormone [LH]) above the normal range.
- Hypogonadotropic hypogonadism (congenital or acquired): gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low testosterone serum concentrations but have gonadotropins in the low or normal range.

## Limitations of Use:

- Safety and efficacy of Xyosted in males less than 18 years old have not been established.

## Compendial Uses

### Testosterone Enanthate Injection, Xyosted

Gender dysphoria<sup>5,7-9</sup> (also known as transgender and gender diverse (TGD) persons)

# Coverage Criteria

## Breast Cancer (Hormone-Responsive Tumor)

Authorization may be granted when the requested drug is being prescribed for a premenopausal patient with breast cancer who has benefited from oophorectomy AND is considered to have a hormone-responsive tumor when ALL of the following criteria are met:

- The requested drug is NOT being prescribed for age-related hypogonadism (also referred to as late-onset 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.]
- The request is for intramuscular testosterone enanthate injection (generic Delatestryl).

## Delayed Puberty

Authorization may be granted when the requested drug is being prescribed for delayed puberty when ALL of the following criteria are met:

- The requested drug is NOT being prescribed for age-related hypogonadism (also referred to as late-onset 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.]
- The request is for intramuscular testosterone enanthate injection (generic Delatestryl).

## Gender Dysphoria

Authorization may be granted when the requested drug is being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy when ALL of the following criteria are met:

- The requested drug is NOT being prescribed for age-related hypogonadism (also referred to as late-onset 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.]
- The patient’s comorbid conditions are reasonably controlled.
- The patient has been educated on ANY contraindications AND side effects to therapy.
- Before the start of therapy, the patient has been informed of fertility preservation options.
- If the patient is less than 18 years of age, then ALL of the following criteria are met:
  - The requested drug is prescribed by, or in consultation with, a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist), that has collaborated care with a mental health provider.

- The patient has reached, or has previously reached, Tanner stage 2 of puberty or greater.

## Inoperable Metastatic Breast Cancer

Authorization may be granted when the requested drug is being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal AND had an incomplete response to other therapy for metastatic breast cancer when ALL of the following criteria are met:

- The requested drug is NOT being prescribed for age-related hypogonadism (also referred to as late-onset 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.]
- The request is for intramuscular testosterone enanthate injection (generic Delatestryl).

## Primary or Hypogonadotropic Hypogonadism

Authorization may be granted when the requested drug is being prescribed for primary or hypogonadotropic hypogonadism when ALL of the following criteria are met:

- The requested drug is NOT being prescribed for age-related hypogonadism (also referred to as late-onset 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.]
- Before the start of testosterone therapy, the patient has at least TWO confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values.

## Continuation of Therapy

### Breast Cancer (Hormone-Responsive Tumor), Delayed Puberty, Inoperable Metastatic Breast Cancer

All patients (including new patients) requesting authorization for continuation of therapy must meet all requirements in the coverage criteria section.

### Primary or Hypogonadotropic Hypogonadism

Authorization may be granted when the requested drug is being prescribed for primary or hypogonadotropic hypogonadism when ALL of the following criteria are met:

- The requested drug is NOT being prescribed for age-related hypogonadism (also referred to as late-onset hypogonadism). [NOTE: Safety and efficacy of testosterone products in patients with

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“age-related hypogonadism” (also referred to as “late-onset hypogonadism”) have not been established.]

- Before the patient started testosterone therapy, the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values.

## Duration of Approval (DOA)

- 1368-A: DOA: 12 months

## References

1. Testosterone Enanthate [package insert]. E. Windsor, NJ: Eugia US LLC; February 2024.
2. Xyosted [package insert]. Ewing, NJ: Antares Pharma, Inc; August 2023.
3. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2025. <https://online.lexi.com>. Accessed February 3, 2025.
4. Lexicomp Online, Lexi-Drugs Online. Waltham, MA: UpToDate, Inc.; 2025. <https://online.lexi.com>. Accessed February 3, 2025.
5. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: 02/03/2025).
6. Bhasin 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.
7. Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int J Transgend Health. 2022;23(S1):S1-S258.
8. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab. 2017;102(11):3869-3903.
9. Health Care for Transgender and Gender Diverse Individuals. ACOG Committee Opinion No. 823. American College of Obstetricians and Gynecologists. Obstet Gynecol. 2021;137:e75-88.

## Document History

Written by: UM Development (JH)

Date: 05/2016

Revised: (CF/JH) 11/2016, 02/2017; (KC) 02/2018, 10/2018 (added Xyosted), 02/2019 (no clinical changes), 06/2019 (updated questions), 02/2020, 02/2021 (added age-related hypogonadism question); (VLS) 02/2022 (removed brand Delatestryl, Aetna alignment TGC coverage criteria update); (MRS) 02/2023 (added Tanner stage 2 criteria for GD if under 18), 02/2024 (no clinical changes), 02/2025 (no clinical changes)

Reviewed: CDPR/Medical Affairs: (ME) 05/2016, 11/2016, 02/2017; (AN) 02/2018; (ME) 10/2018, 07/2019; (CHART) 02/27/20, 02/25/21, 02/24/2022, 04/28/2022, 10/13/2022, 03/02/2023, 02/29/2024, 02/27/2025

External Review: 06/2016, 06/2017, 06/2018, 12/2018, 06/2019, 06/2020, 06/2021, 06/2022, 10/2022, 06/2023, 06/2024, 06/2025

## **CRITERIA FOR APPROVAL**

- |   |  |     |    |
|---|--|-----|----|
| 1 | Is the requested drug being prescribed for age-related hypogonadism (also referred to as late-onset hypogonadism)? [Safety and efficacy of testosterone in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]<br>[If Yes, then no further questions. If No, then go to 2.] | Yes | No |
| 2 | Is the requested drug being prescribed for primary or hypogonadotropic hypogonadism?<br>[If Yes, then go to 3. If No, then go to 6.]   | Yes | No |
| 3 | Is this request for continuation of therapy?<br>[If Yes, then go to 4. If No, then go to 5.]   | Yes | No |
| 4 | Before the patient started testosterone therapy, did the patient have a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values?<br>[No further questions]   | Yes | No |
| 5 | Does the patient have at least TWO confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values, before the start of testosterone therapy?<br>[No further questions]   | Yes | No |
| 6 | Is the requested drug being prescribed for gender dysphoria in a patient who is able to make an informed decision to engage in hormone therapy?<br>[If Yes, then go to 7. If No, then go to 14.]   | Yes | No |
| 7 | Are the patient's comorbid conditions reasonably controlled?<br>[If Yes, then go to 8. If No, then no further questions.]  | Yes | No |
| 8 | Has the patient been educated on ANY contraindications AND side effects to therapy?<br>[If Yes, then go to 9. If No, then no further questions.]   | Yes | No |

9	Is the patient less than 18 years of age? [If Yes, then go to 10. If No, then go to 12.]	Yes	No
10	Is the requested drug being prescribed by, or in consultation with, a provider specialized in the care of transgender youth (e.g., pediatric endocrinologist, family or internal medicine physician, obstetrician-gynecologist), that has collaborated care with a mental health provider? [If Yes, then go to 11. If No, then no further questions.]	Yes	No
11	Has the patient reached, or previously reached, Tanner stage 2 of puberty or greater? [If Yes, then go to 12. If No, then no further questions.]	Yes	No
12	Is the patient new to testosterone therapy? [If Yes, then go to 13. If No, then no further questions.]	Yes	No
13	Has the patient been informed of fertility preservation options? [No further questions]	Yes	No
14	Is this request for intramuscular testosterone enanthate injection (generic Delatestryl)? [If Yes, then go to 15. If No, then no further questions.]	Yes	No
15	Is the requested drug being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal AND had an incomplete response to other therapy for metastatic breast cancer? [If Yes, then no further questions. If No, then go to 16.]	Yes	No
16	Is the requested drug being prescribed for a premenopausal patient with breast cancer who has benefited from oophorectomy AND is considered to have a hormone-responsive tumor? [If Yes, then no further questions. If No, then go to 17.]	Yes	No
17	Is the requested drug being prescribed for delayed puberty? [No further questions]	Yes	No

Mapping Instructions			
	Yes	No	DENIAL REASONS
1.	Deny	Go to 2	We have denied your request because your plan does not cover this drug for age-related hypogonadism, also referred to as late-

			<p>onset hypogonadism. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Exclusion, age-related hypogonadism]</p>
<b>2.</b>	Go to 3	Go to 6	
<b>3.</b>	Go to 4	Go to 5	
<b>4.</b>	Approve, 12 Months	Deny	<p>Your plan only covers this drug when you had a morning testosterone test before you started testosterone treatment and your test results were in a certain range (low). We denied your request because: A) You did not have a morning testosterone test before you started treatment, or B) Your results were not in the approvable range. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Continuation, lab/test]</p>
<b>5.</b>	Approve, 12 Months	Deny	<p>Your plan only covers this drug when you have had two morning testosterone tests before starting treatment and your test results are in a certain range (low). We denied your request because: A) You did not have two morning testosterone tests before starting treatment, or B) Your results were not in the approvable range. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Lab/test]</p>



<b>6.</b>	Go to 7	Go to 14	
<b>7.</b>	Go to 8	Deny	<p>We have denied your request because your plan does not cover this drug unless your other health conditions are under control. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Exclusion, comorbidities]</p>
<b>8.</b>	Go to 9	Deny	<p>Your plan only covers this drug for your health condition when you have been told about reasons you cannot take this drug and side effects of this drug. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Other, education]</p>
<b>9.</b>	Go to 10	Go to 12	
<b>10.</b>	Go to 11	Deny	<p>Your plan only covers this drug when your doctor has expertise in treating your health condition or is working with a doctor who has that knowledge. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Prescriber specialty]</p>
<b>11.</b>	Go to 12	Deny	<p>We have denied your request because your plan does not cover this drug for your health condition unless you have reached a certain stage of puberty. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or</p>

			<p>missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Exclusion, puberty]</p>
<b>12.</b>	Go to 13	Approve, 12 Months	
<b>13.</b>	Approve, 12 Months	Deny	<p>Your plan only covers this drug for your health condition when you have been told about fertility preservation options. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Other, fertility preservation]</p>
<b>14.</b>	Go to 15	Deny	<p>Your plan only covers this drug when it is used for certain health conditions. Covered uses are primary hypogonadism, hypogonadotropic hypogonadism, and certain other health conditions for which you can make an informed decision about using this drug. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Diagnosis, Xyosted]</p>
<b>15.</b>	Approve, 12 Months	Go to 16	
<b>16.</b>	Approve, 12 Months	Go to 17	

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<b>17.</b>	Approve, 12 Months	Deny	<p>Your plan only covers this drug when it is used for certain health conditions. Covered uses are: A) Primary hypogonadism, B) Hypogonadotropic hypogonadism, C) Breast cancer in specific situations, D) Delayed puberty, and E) Certain other health conditions for which you can make an informed decision about using this drug. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Diagnosis, generic Delatestryl]</p>
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