

Clinical Policy: Testosterone Pellet (Testopel)

Reference Number: CP.PHAR.354

Effective Date: 08.01.17

Last Review Date: 11.18

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

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

Description

Testosterone pellet (Testopel[®]) is an implantable androgen.

FDA Approved Indication(s)

Testopel 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 testes syndrome, or orchiectomy
 - Hypogonadotropic hypogonadism (congenital or acquired) - gonadotropic lutenizing hormone-releasing hormone deficiency, or pituitary - hypothalamic injury from tumors, trauma, or radiation
- Treatment of delayed puberty in carefully selected males

Limitation(s) of use: Safety and efficacy of Testopel in men with “age-related hypogonadism” (also referred to as “late-onset hypogonadism”) have not been established.

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 Testopel 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. Documentation of serum testosterone level < 300 ng/dL on at least 2 separate days within the last 6 months;
3. Documentation supports inability to use topical (e.g., patch, gels) and injectable testosterone;
4. Dose does not exceed 450 mg (6 pellets) every 3 months.

Approval duration: 6 months

B. Delayed Puberty (must meet all):

1. Diagnosis of delayed puberty;
2. Prescribed by or in consultation with an endocrinologist;

3. Documentation supports inability to use injectable testosterone;
4. Dose does not exceed 450 mg (6 pellets) every 3 months.

Approval duration: 6 months

C. 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): CP.PMN.53 for Medicaid.

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 450 mg (6 pellets) every 3 months.

Approval duration: 12 months

B. Delayed Puberty (must meet all):

1. Re-authorization is not permitted. Members must meet the initial approval criteria.

Approval duration: Not applicable

C. 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): CP.PMN.53 for Medicaid.

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 – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Men with known carcinoma of the breast or known or suspected carcinoma of the prostate

- Pregnant or breastfeeding women
- 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.
- Androgens may be used cautiously to stimulate puberty in carefully selected patients with clearly delayed puberty. Brief treatment with conservative doses may occasionally be justified in these patients if they do not respond to psychological support.
- Testopel implantation has much less flexibility for dosage adjustment than oral administration or intramuscular injections of oil solutions or aqueous suspensions, requires surgical removal if testosterone should be discontinued, and carries a risk of sloughing out of the skin.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Hypogonadism	150 to 450 mg (2 to 6 pellets) SC every 3 to 6 months For every 25 mg/week of testosterone propionate, 150 mg (2 pellets) should be implanted every 3 to 6 months. If testosterone therapy needs to be discontinued (e.g., for severe adverse reactions), the pellets may need to be removed by a health care professional.	450 mg (6 pellets) every 3 months

VI. Product Availability

Pellet for implantation: 75 mg

VII. References

1. Testopel Prescribing Information. Malvern, PA: Endo Pharmaceutical Inc.; October 2016. Available at: www.testopel.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>.

- 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.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
S0189	Testosterone pellet, 75 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	06.17	11.17
4Q 2018 annual review: split hypogonadism and delayed puberty into two criteria sets; hypogonadism: added requirement for documentation of testosterone levels per PI and guidelines; delayed puberty: added requirement for specialist involvement in care; Testopel: clarified language from failure of other testosterone formulations to inability to use other testosterone formulations; references reviewed and updated.	08.07.18	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.

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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.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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