

Testosterone Products
Effective 07/01/2026

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		
Specialty Limitations	N/A		
Contact Information	Medical Benefit	Phone: 833-895-2611	Fax: 888-656-6671
	Pharmacy Benefit	Phone: 800-711-4555	Fax: 844-403-1029
Exceptions	N/A		

Initial Step-Therapy Requirements:

First-Line: Medications listed on first-line are covered without prior-authorization.

Second-Line: Second-line medications will pay if the member has filled at least two different first-line medications or a second-line medication within the past 180 days.

FIRST-LINE	SECOND-LINE
Testosterone enanthate injection	Testosterone topical solution 30 mg/act (<i>compare to Axiron solution</i>)
Testosterone cypionate injection	Testosterone topical gel 1.62% pump
Testosterone topical gel 1% (<i>compare to AndroGel or Testim</i>)	Testosterone topical gel 1.62% (40.5 MG/2.5GM)
Testosterone topical gel pump 1% (<i>compare to Vogelxo</i>)	
Testosterone topical gel 2% (<i>compare to Fortesta Gel</i>)	

Coverage Guidelines

If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted for members when all the following criteria have been met:

1. Member meets ONE of the following:
 - a. Member has had an inadequate response, adverse reaction or contraindication to two first-line agents
 - b. Member has had an inadequate response, adverse reaction or contraindication to one second-line agent

Limitations

1. Approvals will be granted for 12 months

References

1. AndroGel 1% (testosterone) [prescribing information]. North Chicago, IL: AbbVie Inc; May 2015.
2. AndroGel 1.62% (testosterone) [prescribing information]. North Chicago, IL: AbbVie Inc; May 2019
3. Axiron (testosterone) [prescribing information]. Indianapolis, IN: Eli Lilly and Company; February 2017.
4. Bhasin S, Cunningham GR, Hayes FJ, et al. Testosterone therapy in men with androgen deficiency syndromes: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2010;95(6):2536-2559.[PubMed 20525905]
5. Fortesta (testosterone) gel [prescribing information]. Malvern, PA: Endo Pharmaceuticals Inc; July 2017.
6. Hormone therapy for transgender patients: Journal List Transl Androl Urolv.5(6); 2016 Dec PMC518222
7. Testim (testosterone) [prescribing information]. Malvern, PA: Endo Pharmaceuticals; April 2018.
8. Testosterone gel [prescribing information]. Baudette, MN: Ani Pharmaceuticals, Inc; October 2016.

Review History

09/18/2017: Reviewed

09/24/2018: Reviewed

01/22/2019: Removed clinical rationale from criteria. Only requirement is trials of other 1st line or 2nd line medications.

03/18/2020: Updated (added Jatenzo to 2nd line agent) (effective 6/1/20)

05/19/2021: Updated and Reviewed; Second line agents updated as generic formulations are now available for AndroGel Pump 1.62% and AndroGel topical 1.62%; generic testosterone 1.62% (compare to AndroGel) replaced AndroGel 1.62%. Effective 08/01/2021.

07/20/2022: Updated and Reviewed for July P&T; Added new formulations Tlando as a second line agent. Effective 09/01/2022

09/21/2022: Reviewed and updated for Sept P&T. Added Xyosted as a second line agent. References updated. Separated out Comm/Exch vs. MH. Effective 1/1/2023.

01/11/2023: Reviewed and Updated for Jan P&T; Added new formulation Kyzatrex to ST program as a second line agent. Effective 4/1/2023

10/08/2025 – Reviewed and updated at September P&T. Removed Xyosted, Jatenzo and Kyzatrex from the policy as these agents are moving to nonformulary status. Updated prior authorization language to mirror that of the step therapy configuration. Effective 01/01/2026.

04/15/2026- Reviewed and updated at April P&T. Updating policy to remove Tlando as agent is moving to nonformulary status. Updating policy to indicate that testosterone 1.62% (40 mg/2.5 gram) will be second-line. Removed Andoderm as a second-line agent due to product discontinuation. Effective 07/01/2026.

