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Gaucher's Disease Agents - AZM

**Prior Authorization Guideline**

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| Guideline ID | GL-208206 |
| Guideline Name | Gaucher's Disease Agents - AZM |
| Formulary | * Medicaid - Arizona (AZM, AZMREF, AZMDDD) |

Guideline Note:

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| Effective Date: | 4/1/2025 |

1 .  Criteria

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| Product Name:Cerdelga | |
| Diagnosis | Type 1 Gaucher’s disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Diagnosis of Type 1 Gaucher’s disease  **AND**  **2** - Patient is one of the following as detected by a Food and Drug Administration (FDA)-cleared test:   * CYP2D6 extensive metabolizer * CYP2D6 intermediate metabolizer * CYP2D6 poor metabolizer   **AND**  **3** - Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic miglustat | |

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| Product Name:Cerezyme | |
| Diagnosis | Type 1 Gaucher’s disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Diagnosis of Type 1 Gaucher’s disease that results in one or more of the following conditions:   * Anemia * Thrombocytopenia * Bone disease * Hepatomegaly or splenomegaly   **AND**  **2** - Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to BOTH of the following:   * generic miglustat * Elelyso | |

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| Product Name:Vpriv, Elelyso | |
| Diagnosis | Type 1 Gaucher’s disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Diagnosis of Type 1 Gaucher’s disease  **AND**  **2** - For VPRIV requests ONLY: Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to BOTH of the following:   * generic miglustat * Elelyso | |

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| Product Name:Brand Zavesca, generic miglustat | |
| Diagnosis | Type 1 Gaucher’s disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Diagnosis of mild to moderate Type 1 Gaucher’s disease  **AND**  **2** - For BRAND Zavesca requests ONLY: Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic miglustat (applies to Brand Zavesca requests only) | |

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| Product Name:Cerdelga, Cerezyme, Elelyso, Vpriv, Brand Zavesca, generic miglustat | |
| Diagnosis | Type 1 Gaucher’s disease |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Documentation of positive clinical response to therapy | |

2 .  Revision History

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| --- | --- |
| Date | Notes |
|  | P&T Changes: Cerezyme, Cerdelga, and Vpriv to NP. Step through generic miglustat/Elelyso.Removed step through Brand Zavesca. |

GLP-1 Agonists - AZM

**Prior Authorization Guideline**

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| Guideline ID | GL-219231 |
| Guideline Name | GLP-1 Agonists - AZM |
| Formulary | * Medicaid - Arizona (AZM, AZMREF, AZMDDD) |

Guideline Note:

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| Effective Date: | 4/1/2025 |

1 .  Criteria

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| Product Name:Preferred Drugs: Bydureon, Byetta, Trulicity, Brand Victoza | |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Both of the following:  **1.1** Submission of medical records (e.g. chart notes, lab work, imaging) confirming both of the following:   * Diagnosis of type 2 diabetes mellitus * Baseline A1C greater than or equal to 6.5%   **AND**  **1.2** History of failure to metformin at a minimum dose of 1500 milligrams (mg) daily for 90 days, or contraindication or intolerance to metformin (verified via paid pharmacy claims or submission of medical records)  **AND**  **2** - Patient is 10 years of age or older  **AND**  **3** - Drug is not solely being used for weight loss | |
| Notes | If requested medication is being used solely for appetite suppression or weight loss – deny the case for Plan Exclusion. For all other indications deny the case for medical necessity and do not review for off-label use. |

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| Product Name:Non-Preferred Drugs: Adlyxin, Bydureon BCise, Brand Liraglutide, Mounjaro, Ozempic | |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Both of the following:  **1.1** Submission of medical records (e.g. chart notes, lab work, imaging) confirming both of the following:   * Diagnosis of type 2 diabetes mellitus * Baseline A1C greater than or equal to 6.5%   **AND**  **1.2** History of failure to metformin at a minimum dose of 1500 milligrams (mg) daily for 90 days, or contraindication or intolerance to metformin (verified via paid pharmacy claims or submission of medical records)  **AND**  **2** - History of a 90 day trial per member's pharmacy claims resulting in a therapeutic failure, contraindication, or intolerance to ALL of the following (verified via paid pharmacy claims or submission of medical records):   * Byetta * Brand Victoza * Trulicity   **AND**  **3** - One of the following:   * For Bydureon BC ONLY: Patient is 10 years of age or older * For Adlyxin, Mounjaro, Ozempic ONLY: Patient is 18 years of age or older   **AND**  **4** - Drug is not solely being used for weight loss | |
| Notes | If requested medication is being used solely for appetite suppression or weight loss – deny the case for Plan Exclusion. For all other indications deny the case for medical necessity and do not review for off-label use. |

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| Product Name:Non-Preferred: Rybelsus | |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Both of the following:  **1.1** Submission of medical records (e.g. chart notes, lab work, imaging) confirming both of the following:   * Diagnosis of type 2 diabetes mellitus * Baseline A1C greater than or equal to 6.5%   **AND**  **1.2** History of failure to metformin at a minimum dose of 1500 milligrams (mg) daily for 90 days, or contraindication or intolerance to metformin (verified via paid pharmacy claims or submission of medical records)  **AND**  **2** - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:  **2.1** History of a 90 day trial per member's pharmacy claims resulting in a therapeutic failure, contraindication, or intolerance to ALL of the following (verified via paid pharmacy claims or submission of medical records):   * Byetta * Brand Victoza * Trulicity   **or**  **2.2** BOTH of the following:  **2.2.1** The patient is unable to self-inject due to ONE of the following:   * Physical impairment * Visual impairment * Lipohypertrophy * Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria)   **AND**  **2.2.2** History of failure, intolerance, or contraindication to ALL of the following:   * Farxiga * Jardiance * Synjardy * Xigduo XR   **AND**  **3** - Patient is 18 years of age or older  **AND**  **4** - Drug is not solely being used for weight loss | |
| Notes | If requested medication is being used solely for appetite suppression or weight loss – deny the case for Plan Exclusion. For all other indications deny the case for medical necessity and do not review for off-label use. |

2 .  Revision History

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| --- | --- |
| Date | Notes |
|  | P&T Changes: Rybelsus, removed step through Invokana (now NP). Added new GPIs for Rybelsus. |

Pulmonary Arterial Hypertension (PAH) Agents

**Prior Authorization Guideline**

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| Guideline ID | GL-208208 |
| Guideline Name | Pulmonary Arterial Hypertension (PAH) Agents |
| Formulary | * Medicaid - Arizona (AZM, AZMREF, AZMDDD) |

Guideline Note:

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| Effective Date: | 4/1/2025 |

1 .  Criteria

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| Product Name:PREFERRED DRUGS: Alyq, generic tadalafil, generic ambrisentan, Orenitram, generic sildenafil suspension, generic sildenafil tablets, Tracleer tablet for oral suspension; NON-PREFERRED DRUGS: Brand Adcirca, Adempas, Brand Flolan, Brand Veletri, generic eprostenol, Brand Letairis, Opsumit, Opsynvi, Brand Remodulin, generic trepostinil, Brand Revatio tablets, Brand Revatio injection, generic sildenafil injection, Tadliq suspension, Brand Tracleer tablet, generic bosentan, Tyvaso DPI, Tyvaso inhaltion solution, Uptravi, Ventavis | |
| Diagnosis | Pulmonary Arterial Hypertension |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Diagnosis of pulmonary arterial hypertension  **AND**  **2** - Pulmonary arterial hypertension is symptomatic  **AND**  **3** - One of the following:  **3.1** Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization  **or**  **3.2** Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension  **AND**  **4** - Prescribed by or in consultation with one of the following:   * Pulmonologist * Cardiologist   **AND**  **5** - If the patient is requesting a non preferred product, patient has a history of failure, contraindication or intolerance to BOTH of the following:   * A preferred Endothelin Receptor Antagonist (ERA) (e.g., generic ambrisentan, Tracleer tablet for oral suspension)) * A preferred Phosphodiesterase 5 inhibitor (PDE5i) [e.g., Alyq or tadalafil, generic sildenafil tablet (generic for Revatio tablet), generic sildenafil suspension]   **AND**  **6** - If the request is for Brand Adcirca, patient must have tried and failed generic tadalafil or Alyq  **AND**  **7** - If the request is for Opsynvi, patient must have tried and failed both of the following as separate products:   * generic tadalafil * Opsumit (may require PA) | |

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| Product Name:Adempas tablet | |
| Diagnosis | Chronic Thromboembolic Pulmonary Hypertension (CTEPH) |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - One of the following:  **1.1** Both of the following:  **1.1.1** Diagnosis of inoperable or persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH)  **AND**  **1.1.2** CTEPH is symptomatic  **or**  **1.2** Patient is currently on any therapy for the diagnosis of CTEPH  **AND**  **2** - Prescribed by or in consultation with one of the following:   * Pulmonologist * Cardiologist | |

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| --- | --- |
| Product Name:PREFERRED DRUGS: Alyq, generic tadalafil, generic ambrisentan, Orenitram, generic sildenafil suspension, generic sildenafil tablets, Tracleer tablet for oral suspension; NON-PREFERRED DRUGS: Brand Adcirca, Adempas, Brand Flolan, Brand Veletri, generic eprostenol, Brand Letairis, Opsumit, Opsynvi, Brand Remodulin, generic trepostinil, Brand Revatio tablets, Brand Revatio injection, generic sildenafil injection, Tadliq suspension, Brand Tracleer tablet, generic bosentan, Tyvaso DPI, Tyvaso inhaltion solution, Uptravi, Ventavis | |
| Diagnosis | All indications listed above |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Documentation of positive clinical response to therapy | |

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| --- | --- |
| Product Name:Winrevair Injection | |
| Diagnosis | Pulmonary Arterial Hypertension |
| Approval Length | 6 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Diagnosis of pulmonary arterial hypertension  **AND**  **2** - Pulmonary arterial hypertension is symptomatic  **AND**  **3** - Patient is currently on at least two therapies indicated for the treatment of pulmonary arterial hypertension from the following different mechanisms of action, unless there is a contraindication or intolerance:   * Endothelin receptor antagonists (i.e., Bosentan, ambrisentan or macitentan) * Phosphodiesterase 5 inhibitors (i.e., Tadalafil or sildenafil)   **AND**  **4** - Prescribed by or in consultation with one of the following:   * Pulmonologist * Cardiologist | |

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| --- | --- |
| Product Name:Winrevair Injection | |
| Diagnosis | Pulmonary Arterial Hypertension |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Patient demonstrates positive clinical response to therapy | |

2 .  Revision History

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| --- | --- |
| Date | Notes |
|  | P&T changes: Tracleer (tab for oral susp) to preferred, generic bosentan to NP. |

SGLT-2 Inhibitors - AZM

**Prior Authorization Guideline**

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| Guideline ID | GL-208205 |
| Guideline Name | SGLT-2 Inhibitors - AZM |
| Formulary | * Medicaid - Arizona (AZM, AZMREF, AZMDDD) |

Guideline Note:

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| Effective Date: | 4/1/2025 |

1 .  Criteria

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| --- | --- |
| Product Name:Brand Farxiga, generic dapagliflozin | |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - One of the following:  **1.1** All of the following:   * Patient is 10 years of age or older * Diagnosis of type 2 diabetes mellitus * History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin   **or**  **1.2** One of the following:   * Diagnosis of chronic kidney disease (CKD) * Diagnosis of heart failure (NYHA class II-IV) with reduced ejection fraction * Diagnosis of heart failure (NYHA class II-IV) with preserved ejection fraction   **AND**  **2** - For generic dapagliflozin requests ONLY: History of failure, intolerance, or contraindication to Brand Farxiga | |

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| Product Name:Jardiance, Synjardy, Synjardy XR | |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - One of the following:  **1.1** All of the following:   * Patient is 10 years of age or older * Diagnosis of type 2 diabetes mellitus * History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin.   **or**  **1.2** Both of the following:   * Requested medication is being used to reduce the risk of cardiovascular death in adults with type 2 diabetes mellitus and established cardiovascular disease * History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin.   **or**  **1.3** Requested medication is being used for one of the following :   * To reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure * To reduce the risk of sustained decline in eGFR, end-stage kidney disease, cardiovascular death, and hospitalization in adults with chronic kidney disease at risk of progression.   **AND**  **2** - For Synjardy XR requests ONLY; History of failure, intolerance, or contraindication to ALL of the following:   * Farxiga * Jardiance | |

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| Product Name:Inovkana, Invokamet, Invokamet XR, Segluromet, Steglatro, Trijardy XR | |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Both of the following:   * Diagnosis of type 2 diabetes mellitus * History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin   **AND**  **2** - History of failure, intolerance, or contraindication to ALL of the following:   * Farxiga * Jardiance   **AND**  **3** - Patient is 10 years of age or older (applies to Invokana, Invokamet, Invokamet XR ONLY) | |

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| Product Name:Brand Xigduo XR, generic dapagliflozin-metformin | |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - One of the following:  **1.1** All of the following:   * Patient is 10 years of age or older * Diagnosis of type 2 diabetes mellitus * History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin.   **or**  **1.2** One of the following:   * Diagnosis of chronic kidney disease (CKD) * Diagnosis of heart failure (NYHA class II-IV) with reduced ejection fraction   **AND**  **2** - For generic dapagliflozin-metformin requests ONLY: History of failure, intolerance, or contraindication to Brand Xigduo XR | |

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| Product Name:Brand Bexagliflozin, Brenzavvy, Glyxambi, Qtern, Steglujan | |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Both of the following:   * Diagnosis of type 2 diabetes mellitus * History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin   **AND**  **2** - History and failure, intolerance, or contraindication to ALL of the following:   * Janumet or Janumet XR * Januvia * Jentadueto or Jentadueto XR * Kombiglyze XR * Onglyza * Tradjenta * Trijardy XR   **AND**  **3** - History of failure, intolerance, or contraindication to ALL of the following:   * Farxiga * Jardiance | |

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| --- | --- |
| Product Name:Inpefa | |
| Approval Length | 12 month(s) |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Requested medication is being used to reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit in adults with one of the following:   * heart failure * type 2 diabetes mellitus, chronic kidney disease, and other cardiovascular risk factors   **AND**  **2** - History of failure, intolerance, or contraindication to Farxiga | |

2 .  Revision History

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| --- | --- |
| Date | Notes |
|  | P&T changes: Invokana/Invokamet to NP. Removed Invokana as preferred t/f alt. Moved Synjardy/XR to Jardiance section due to expanded indication. |

Testosterone - AZM

**Prior Authorization Guideline**

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| Guideline ID | GL-208207 |
| Guideline Name | Testosterone - AZM |
| Formulary | * Medicaid - Arizona (AZM, AZMREF, AZMDDD) |

Guideline Note:

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| Effective Date: | 4/1/2025 |

1 .  Criteria

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| Product Name:Brand Androgel pump, generic testosterone 1.62% pump (generic Androgel pump), Brand Androgel gel, generic testosterone gel (generic Androgel), testosterone enanthate, testosterone topical 30mg/act solution, testosterone cypionate, Brand Testim, generic testosterone 50mg/5gm TD gel (generic Testim), Brand Vogelxo, generic testosterone TD gel (generic Vogelxo), Azmiro, Jatenzo, Kyzatrex, Tlando, Undecatrex | |
| Diagnosis | Hypogonadism |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:  **1.1** TWO pre-treatment serum total testosterone levels less than 300 ng/dL (less than 10.4 nmol/L) or less than the reference range for the lab, taken at separate times (Document lab value and date for both levels)  **or**  **1.2** BOTH of the following:  **1.2.1** Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)  **AND**  **1.2.2** ONE pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (less than 5 ng/dL or less than 0.17 nmol/L) or less than the reference range for the lab (This may require treatment to be temporarily held. Document lab value and date)  **or**  **1.3** Patient has a history of ONE of the following:   * Bilateral orchiectomy * Panhypopituitarism * A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter’s syndrome)   **AND**  **2** - Patient is NOT taking ONE of the following growth hormones, unless diagnosed with panhypopituitarism:   * Genotropin * Humatrope * Norditropin FlexPro * Nutropin AQ * Omnitrope * Saizen   **AND**  **3** - Patient is NOT taking with an Aromatase inhibitor (eg, Arimidex [anastrozole], Femara [letrozole], or Aromasin [exemestane])  **AND**  **4** - Patient was male at birth  **AND**  **5** - Diagnosis of hypogonadism  **AND**  **6** - ONE of the following:   * Significant reduction in weight (less than 90 percent ideal body weight) (e.g., AIDS wasting syndrome) * Osteopenia * Osteoporosis * Decreased bone density * Decreased libido * Organic cause of testosterone deficiency (eg, injury, tumor, infection, or genetic defects)   **AND**  **7** - If the request is for AZMIRO, JATENZO, KYZATREX, TLANDO, UNDECATREX, BRAND VOGELXO or GENERIC TESTOSTERONE 1% GEL; Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic testosterone 1.62% gel (generic for Androgel by preferred manufacturers) (Applies to Azmiro, Jatenzo, Kyzatrex, Tlando, Undecatrex, and Brand/generic Vogelxo only) | |

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| --- | --- |
| Product Name:Brand Androgel pump, generic testosterone 1.62% pump (generic Androgel pump), Brand Androgel gel, generic testosterone gel (generic Androgel), testosterone enanthate, testosterone topical 30mg/act solution, testosterone cypionate, Brand Testim, generic testosterone 50mg/5gm TD gel (generic Testim), Brand Vogelxo, generic testosterone TD gel (generic Vogelxo), Azmiro, Jatenzo, Kyzatrex, Tlando, Undecatrex | |
| Diagnosis | Gender Dysphoria |
| Approval Length | 12 month(s) |
| Therapy Stage | Initial Authorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Patient is using hormones to change physical characteristics  **AND**  **2** - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)  **AND**  **3** - Patient is NOT taking ONE of the following growth hormones, unless diagnosed with panhypopituitarism:   * Genotropin * Humatrope * Norditropin FlexPro * Nutropin AQ * Omnitrope * Saizen   **AND**  **4** - Patient is NOT taking with an Aromatase inhibitor (eg, Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])  **AND**  **5** - If the request is for AZMIRO, JATENZO, KYZATREX, TLANDO, UNDECATREX, BRAND VOGELXO or GENERIC TESTOSTERONE 1% GEL; Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic testosterone 1.62% gel (generic for Androgel by preferred manufacturers) (Applies to Azmiro, Jatenzo, Kyzatrex, Tlando, Undecatrex, and Brand/generic Vogelxo only) | |

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| --- | --- |
| Product Name:Brand Androgel pump, generic testosterone 1.62% pump (generic Androgel pump), Brand Androgel gel, generic testosterone gel (generic Androgel), testosterone enanthate, testosterone topical 30mg/act solution, testosterone cypionate, Brand Testim, generic testosterone 50mg/5gm TD gel (generic Testim), Brand Vogelxo, generic testosterone TD gel (generic Vogelxo), Azmiro, Jatenzo, Kyzatrex, Tlando, Undecatrex | |
| Diagnosis | Hypogonadism, Gender Dysphoria |
| Approval Length | 12 month(s) |
| Therapy Stage | Reauthorization |
| Guideline Type | Prior Authorization |
| **Approval Criteria**  **1** - Submission of medical records (e.g., chart notes) documenting ONE of the following:  **1.1** Follow-up total serum testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document value and date)  **or**  **1.2** Follow-up total serum testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)  **or**  **1.3** BOTH of the following:  **1.3.1** Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)  **AND**  **1.3.2** ONE of the following:  **1.3.2.1** Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document lab value and date)  **or**  **1.3.2.2** Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)  **AND**  **2** - Patient is NOT taking ONE of the following growth hormones, unless diagnosed with panhypopituitarism:   * Genotropin * Humatrope * Norditropin FlexPro * Nutropin AQ * Omnitrope * Saizen   **AND**  **3** - Patient is NOT taking with an Aromatase inhibitor (eg, Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])  **AND**  **4** - If the request is for AZMIRO, JATENZO, KYZATREX, TLANDO, UNDECATREX, BRAND VOGELXO or GENERIC TESTOSTERONE 1% GEL; Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic testosterone 1.62% gel (generic for Androgel by preferred manufacturers) (Applies to Azmiro, Jatenzo, Kyzatrex, Tlando, Undecatrex, and Brand/generic Vogelxo only) | |

2 .  Revision History

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| --- | --- |
| Date | Notes |
|  | P&T changes: Brand/generic Vogelxo to NP, updated embedded steps. |