DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD

PROPOSED UPDATED PRIOR AUTHORIZATION CRITERION

Cass Name: Topical Androgens

Generic Name: Testosterone gel and transdermal system

Brand Name: Androgel®, Androderm®, Testim®

Coverage and Limitations:

Topical androgens (testosterone) are a covered benefit of Nevada Medicaid for recipients who meet the criteria for coverage.

1. Criteria for Approval:

   A. Recipient is a male AND

   B. Use is for the FDA Approved Indication:

      i. Primary (congenital or acquired) or secondary (congenital or acquired) hypogonadism with ICD-9 diagnosis code of 257.2 AND

   C. Two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used.

2. Topical Androgens (testosterone) will NOT be approved if ANY of the following conditions exists:

   A. Breast or Prostate cancer.

   B. A palpable prostate nodule or induration or prostate-specific antigen greater than 4 ng/ml.

   C. A hematocrit > 50%

   D. Untreated severe obstructive sleep apnea.

   E. Severe lower urninary symptoms with International Prostate Symptom Score (IPSS) > 19

   F. Uncontrolled or poorly controlled heart failure

Length of authorization: 1 year