# SUBCUTANEOUS IMPLANTABLE HORMONE PELLETS

**Policy Number**: 2019D0076B **Effective Date**: March 1, 2019

Instructions for Use

**Table of Contents** **Page**



**Related Commercial Policies**

None

## COVERAGE RATIONALE

See Benefit Considerations

**I. Testopel (testosterone pellets) is proven for replacement therapy in conditions associated with a deficiency or absence of endogenous testosterone, including primary hypogonadism and hypogonadotropic hypogonadism.**[1]

**Testopel (testosterone pellets) is medically necessary for replacement therapy in conditions associated with a deficiency or absence of endogenous testosterone, including primary hypogonadism and hypogonadotropic hypogonadism, when the following criteria are met:**

A. For **initial therapy**, **one** of the following:
   1. Two pre-treatment fasting morning serum total testosterone levels less than 300 ng/dL (<10.4 nmol/L) or less than the reference range for the lab, taken at separate times (this may require treatment to be temporarily held) (document lab value and date for both levels); **or**
   2. **Both** of the following:
      a. Patient has condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity); **and**
      b. **One** pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (<5 ng/dL or < 0.17 nmol/L) or less than the reference range for the lab (this may require treatment to be temporarily held)

      **or**
   3. **All** of the following:
      a. Patient has history of **one** of the following:
         i. Bilateral orchiectomy; **or**
         ii. Panhypopituitarism (defined as two or more pituitary hormone insufficiencies prior to the diagnosis of hypogonadism); **or**
         iii. A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

         **and**
      b. Patient is not taking any of the following growth hormones, unless diagnosed with panhypopituitarism: Genotropin, Humatrope, Norditropin FlexPro, Norditropin NordiFlex, Nutropin, Nutropin AQ, Omnitrope, Saizen, Tev-Tropin; **and**
      c. Patient was male at birth; **and**
      d. Diagnosis of hypogonadism; **and**
      e. **One** of the following:
         i. Significant reduction in weight (< 90% ideal body weight) (e.g., AIDS wasting syndrome); **or**
         ii. Osteopenia; **or**
         iii. Osteoporosis; **or**
         iv. Decreased bone density; **or**

v. Decreased libido; **or**
vi. Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)

**and**

4. Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
5. Initial authorization will be for no more than 6 months for new starts, 12 months for patients continuing therapy.

B. For **continuation of therapy**, **all** of the following:
1. **One** of the following:
   a. Follow-up total serum testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), is **within** or below the normal male limits of the reporting lab; **or**
   b. Follow up total serum testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), is **outside** of upper male limits of normal for the reporting lab and the dose is adjusted; **or**
   c. **Both** of the following
      i. Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity); **and**
      ii. **One** of the following:
         1) Follow-up calculated free or bioavailable testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), is **within** or below the normal male limits of the reporting lab; **or**
         2) Follow-up calculated free or bioavailable testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), is **outside** of upper male limits of normal for the reporting lab and the dose is adjusted

**and**

2. Patient is not taking any of the following growth hormones, unless diagnosed with panyhypopituitarism: Genotropin, Humatrope, Norditropin FlexPro, Norditropin NordiFlex, Nutropin, Nutropin AQ, Omnitrope, Saizen, Tev-Tropin; **and**
3. Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
4. Initial authorization will be for no more than 12 months.

**II. Testopel (testosterone pellet) is medically necessary for gender-affirming hormonal therapy for transgender adults when the following criteria are met:**

A. For **initial therapy**, **all** of the following:
1. Diagnosis of gender dysphoria, according to the current DSM (i.e., DSM-5) criteria, by a mental health professional; **and**
2. Medication is prescribed by or in consultation with an endocrinologist or a medical provider knowledgeable in transgender hormone therapy; **and**
3. Patient is not taking any of the following any of the following growth hormones, unless diagnosed with panyhypopituitarism: Genotropin, Humatrope, Norditropin FlexPro, Norditropin NordiFlex, Nutropin, Nutropin AQ, Omnitrope, Saizen, or Tev-Tropin; **and**
4. Authorization will be for no more than 12 months.

B. For **continuation of therapy**, **all** of the following:
1. Diagnosis of gender dysphoria, according to the current DSM (i.e., DSM-5) criteria, by a mental health professional; **and**
2. Medication is prescribed by or in consultation with an endocrinologist or a medical provider knowledgeable in transgender hormone therapy; **and**
3. **One** of the following:
   a. Follow-up total serum testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), is **within** or below the normal male limits of the reporting lab; **or**
   b. Follow up total serum testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), is **outside** of upper male limits of normal for the reporting lab and the dose is adjusted; **or**
   c. **Both** of the following
      i. Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity); **and**

ii. **One** of the following
   1) Follow-up calculated free or bioavailable testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), is **within** or below the normal male limits of the reporting lab; **or**
   2) Follow-up calculated free or bioavailable testosterone level drawn within the past 6 months for patients new to testosterone therapy (i.e., on therapy for less than one year), or 12 months for patients continuing testosterone therapy (i.e., on therapy for one year or longer), is **outside** of upper male limits of normal for the reporting lab and the dose is adjusted

**and**

4. Patient is not taking any of the following growth hormones, unless diagnosed with panyhypopituitarism: Genotropin, Humatrope, Norditropin FlexPro, Norditropin NordiFlex, Nutropin, Nutropin AQ, Omnitrope, Saizen, or Tev-Tropin; **and**
5. Authorization will be for no more than 12 months.

**III. Compounded Hormone Pellets**

Compounded hormone pellets, including but not limited to compounded testosterone, estrogen, and progesterone pellets are **not** proven or medically necessary for any indication. Compounded drugs, including compounded testosterone, estrogen, or progesterone pellets are not FDA approved.[3]

## U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Androgens are 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 LHRH deficiency, or pituitary - hypothalamic injury from tumors, trauma or radiation.

Safety and efficacy of Testopel (testosterone pellets) in men with age-related hypogonadism, also referred to as late-onset hypogonadism, have not been established.

Compounded testosterone, estrogen, and progesterone pellets are not currently FDA approved and there has not been an FDA submission for approval of these products.

## BACKGROUND

Endogenous androgens are responsible for the normal growth and development of the male sex organs and for maintenance of secondary sex characteristics. These effects include the growth and maturation of prostate, seminal vesicles, penis and scrotum; the development of male hair distribution such as beard, pubic, chest and axillary hair, laryngeal enlargements, vocal cord thickening, alterations in body musculature and fat distribution.[1]

## APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

| CPT Code | Description |
|---|---|
| 11980 | Subcutaneous hormone pellet implantation |



| HCPCS Code | Description |
|---|---|
| S0189 | Testopel 75 MG PLLT S0189 Testosterone pellet, 75 mg |

| ICD-10 Diagnosis Code | Description |
|---|---|
| E30.0 | Delayed puberty |
| F64.0 | Transsexualism |
| N44.00 | Torsion of testis, unspecified |

| ICD-10 Diagnosis Code | Description |
|---|---|
| Q53.00 | Ectopic testis, unspecified |
| Q53.111 | Unilateral intraabdominal testis |
| Q53.112 | Unilateral inguinal testis |
| Q53.20 | Undescended testicle, unspecified, bilateral |
| Q53.211 | Bilateral intraabdominal testes |
| Q53.212 | Bilateral inguinal testes |
| Q53.22 | Ectopic perineal testis, bilateral |
| Q55.0 | Absence and aplasia of testis |
| Z87.890 | Personal history of sex reassignment |
| Z90.79 | Acquired absence of other genital organ(s) |
| N45.2 | Orchitis |
| Q53.01 | Ectopic testis, unilateral |
| Q53.02 | Ectopic testes, bilateral |
| Q53.9 | Undescended testicle, unspecified |
| Q53.10 | Unspecified undescended testicle, unilateral |
| Q53.12 | Ectopic perineal testis, unilateral |
| F64.1 | Dual role transvestism |
| F64.2 | Gender identity disorder of childhood |
| F64.8 | Other gender identity disorders |
| F64.9 | Gender identity disorder, unspecified |
| E89.3 | Postprocedural hypopituitarism |
| E89.5 | Postprocedural testicular hypofunction |
| E29.1 | Testicular hypofunction |
| E23.0 | Hypopituitarism |
| E23.3 | Hypothalamic dysfunction, not elsewhere classified |

## BENEFIT CONSIDERATIONS

Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy. Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met. See the Policy and Procedure addressing the treatment of serious rare diseases.

## CLINICAL EVIDENCE

In the 2018 update to the Testosterone Therapy in Men With Androgen Deficiency Syndromes guideline published in 2010, the authors recommend making a diagnosis of hypogonadism only in men with symptoms and signs consistent with testosterone (T) deficiency.[9] The group recommends fasting morning total T concentrations along with confirmation be used for monitoring. Measurement of free T concentration should be completed when total T is near the lower limit of normal or when a condition that alters sex hormone-binding globulin is present. Upon confirmation of androgen deficiency, the committee recommends additional diagnostic evaluation to determine the cause. T therapy is recommended for symptomatic men with T deficiency to induce and maintain secondary sex characteristics and correct symptoms of hypogonadism. Potential benefits and risks and benefits of T replacement should be discussed with the patient prior to initiating therapy. Upon initiation of T therapy, T concentration goals should be in the mid-normal range during treatment with any of the approved formulations, taking into consideration patient preference, pharmacokinetics, formulation-specific adverse effects, treatment burden, and cost. Men receiving T therapy should be monitored to evaluate symptoms, adverse effects, and compliance; measuring serum T and hematocrit concentrations; and evaluate prostate cancer risk after initiating T therapy.

## CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does not have a National Coverage Determination (NCD) for testosterone pellets (Testopel®). Local Coverage Determinations (LCDs) exist; see the LCDs for Testosterone pellets (Testopel®) and Treatment of Males with Low Testosterone.

Medicare may cover outpatient (Part B) drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. See the Medicare Benefit Policy Manual, Chapter 15, §50 Drugs and Biologicals. (Accessed April 17, 2018)

## REFERENCES


1. Testopel [prescribing information]. Malvern, PA: Endo Pharmaceuticals, Inc.; October 2016.
2. Seftel A. Testosterone replacement therapy for male hypogonadism: Part III. Pharmacologic and clinical profiles, monitoring, safety issues, and potential future agents. Int J Impot Res. 2007;19(1):2-24.
3. FDA Compounding Laws and Policies. https://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm606881.htm. Accessed June 11, 2018.
4. Mulhall JP, et al. Evaluation and Management of Testosterone Deficiency: AUA Guideline. American Urological Association Education and Research, Inc 2018.
5. U.S. Food and Drug Administration (FDA). Testosterone Products: Drug Safety Communication. https://www.fda.gov/Drugs/DrugSafety/ucm436259.htm. Accessed June 8, 2018
6. The World Professional Association for Transgender Health (WPATH), Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version.
7. Bhasin, S, et al. Testosterone replacement and resistance exercise in HIV-infected men with weight loss and low testosterone levels. *JAMA*. 2000. 283.(6) 763-770.
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; 102:3869.
9. The Endocrine Society. Testosterone therapy in Adult Men with Androgen Deficiency Syndromes. J Clin Endocrinol Metab, May 2018, 103(5):1–30.


## POLICY HISTORY/REVISION INFORMATION

| Date | Action/Description |
|---|---|
| 03/01/2019 | • Reorganized policy template; simplified and relocated *Instructions for Use* and *Benefit Considerations* section<br>• Archived previous policy version 2019D0076A |
| 02/01/2019 | • New policy |

## INSTRUCTIONS FOR USE

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard benefit plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Benefit Drug Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.