

Testosterone Replacement or Supplementation Therapy

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[Instructions for Use](#)

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Related Policies
None

Applicable States

This Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York.

Coverage Rationale

[See Benefit Considerations](#)

This policy refers to the following testosterone products:

- Testosterone cypionate (Azmiro™, Depo-Testosterone®)
- Testosterone enanthate
- Testosterone pellets (Testopel®)
- Testosterone undecanoate (Aveed®)

Preferred Product

Medical Necessity Plans

Coverage for the following preferred testosterone products [testosterone cypionate (Depo-Testosterone®), testosterone enanthate, testosterone pellets (Testopel®), and testosterone undecanoate (Aveed®)] is contingent on criteria in the [Diagnosis-Specific Requirements](#) sections.

Coverage for Azmiro or other non-preferred testosterone products will be provided contingent on the criteria in this Preferred Product Criteria section and the coverage criteria in the [Diagnosis-Specific Criteria](#) section. In order to continue Azmiro or other non-preferred testosterone product will be required to change therapy to a preferred testosterone product unless they meet the criteria in this section.

Preferred Product Criteria

Treatment with Azmiro or other non-preferred testosterone product is medically necessary for the indications specified in this policy when one of the following criteria are met:

- Both of the following:

- History of a trial of adequate dose and duration of a preferred product resulting in minimal clinical response; **and**
 - Physician attests that, in their clinical opinion, the clinical response would be expected to be superior with Azmiro or other non-preferred testosterone product, than experienced with a preferred product
- or**
- **Both** of the following:
 - History of intolerance, contraindication, or adverse event to a preferred product; **and**
 - Physician attests that, in their clinical opinion, the same intolerance, contraindication, or adverse event would not be expected to occur with Azmiro or other non-preferred testosterone product

Non-Medical Necessity Plans

Any testosterone product is to be approved contingent on the coverage criteria in the [Diagnosis-Specific Criteria](#) section.

Diagnosis-Specific Requirements

The information below indicates the list of proven and medically necessary indications.

Injectable testosterone and Testopel (testosterone pellets) are proven for replacement therapy in conditions associated with a deficiency or absence of endogenous testosterone, including primary hypogonadism (congenital or acquired) and hypogonadotropic hypogonadism (congenital or acquired).

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

- **One** of the following:
 - Patient has history of **one** of the following:
 - Bilateral orchiectomy; **or**
 - Panhypopituitarism; **or**
 - A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter’s syndrome)
 - or**
 - **All** of the following:
 - **One** of the following:
 - Two pre-treatment early 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; **or**
 - **Both** of the following:
 - Patient has condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity); and
 - 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
 - or**
 - **Both** of the following:
 - Patient is currently on testosterone therapy; **and**
 - **One** of the following:
 - 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**
 - 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**
 - Patient was male at birth; **and**
 - Diagnosis of hypogonadism
- and**
- Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
 - Authorization will be for no more than 12 months

Injectable testosterone and Testopel (testosterone pellets) may be covered for gender-affirming hormonal therapy for transgender adults when all of the following criteria are met:

- Diagnosis of gender dysphoria, according to the current DSM (i.e., DSM-5-TR) criteria, by a mental health professional; **and**
- Medication is prescribed by or in consultation with an endocrinologist or a medical provider knowledgeable in transgender hormone therapy; **and**
- Authorization will be for no more than 12 months

Compounded hormone products (e.g., 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

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 Guidelines may apply.

CPT Code	Description
11980	Subcutaneous hormone pellet implantation

CPT® is a registered trademark of the American Medical Association

HCPCS Code	Description
J1071	Injection, testosterone cypionate, 1 mg
J1072	Injection, testosterone cypionate (Azmiro), 1 mg
J1073	Testosterone pellet, implant, 75 mg
J3121	Injection, testosterone enanthate, 1 mg
J3145	Injection, testosterone undecanoate, 1 mg

Diagnosis Code	Description
E23.0	Hypopituitarism
E23.3	Hypothalamic dysfunction, not elsewhere classified
E29.1	Testicular hypofunction
E30.0	Delayed puberty
E89.3	Postprocedural hypopituitarism
E89.5	Postprocedural testicular hypofunction
F64.0	Transsexualism
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
N44.00	Torsion of testis, unspecified
N45.2	Orchitis
Q53.00	Ectopic testis, unspecified
Q53.01	Ectopic testis, unilateral
Q53.02	Ectopic testes, bilateral
Q53.10	Unspecified undescended testicle, unilateral
Q53.111	Unilateral intraabdominal testis
Q53.112	Unilateral inguinal testis
Q53.12	Ectopic perineal testis, unilateral
Q53.20	Undescended testicle, unspecified, bilateral

Diagnosis Code	Description
Q53.211	Bilateral intraabdominal testes
Q53.212	Bilateral inguinal testes
Q53.22	Ectopic perineal testis, bilateral
Q53.9	Undescended testicle, unspecified
Q55.0	Absence and aplasia of testis
Z87.890	Personal history of sex reassignment
Z90.79	Acquired absence of other genital organ(s)

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

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. Refer to 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.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

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 (luteinizing hormone-releasing hormone) 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. The dosage guideline for the testosterone pellets for replacement therapy in androgen-deficient males is 150mg to 450mg subcutaneously every 3 to 6 months. The usual dosage is as

follows: implant two 75mg pellets for each 25mg testosterone propionate required weekly. Thus when a patient requires injections of 75mg per week, it is usually necessary to implant 450mg (6 pellets). With injections of 50mg per week, implantation of 300mg (4 pellets) may suffice for approximately three months.

Aveed (testosterone undecanoate injection) is administered 750mg initially, at week 4, then every 10 weeks thereafter.

Testosterone cypionate and testosterone enanthate injections are administered 50 mg to 400 mg every 2 to 4 weeks, not to exceed 400 mg per month.

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

References

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10. Depo-testosterone [prescribing information]. New York, NY: Pharmacia & Upjohn Co.; August 2018.
11. Aveed [prescribing information]. Malvern, PA: Endo Pharmaceuticals; August 2021.
12. Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *Int J Transgend Health.* 2022;23(Suppl 1):S1-S259. Published 2022 Sep 6. doi:10.1080/26895269.2022.2100644.
13. Qaseem A, Horwitch CA, Vijan S, et al. Testosterone Treatment in Adult Men With Age-Related Low Testosterone: A Clinical Guideline From the American College of Physicians. *Ann Intern Med.* 2020;172(2):126-133. doi:10.7326/M19-0882.
14. Azmiro [prescribing information]. Woburn, MA: Azurity Pharmaceuticals, Inc.; July 2025.

Policy History/Revision Information

Date	Summary of Changes
01/01/2026	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Removed reference link to the Medical Benefit Drug Policy titled <i>Review at Launch for New to Market Medications</i> for Azmiro™ (testosterone cypionate) Added language to indicate: <ul style="list-style-type: none"> Azmiro™ is typically excluded from coverage and coverage reviews may be in place if required by law or the benefit plan; refer to the Medical Benefit Drug Policy titled <i>Medical Benefit Therapeutic Equivalent Medications – Excluded Drugs</i> and the corresponding excluded drug list with preferred alternatives

Date	Summary of Changes
	<ul style="list-style-type: none"> ○ For requests that require medical necessity review, also refer to the <i>Diagnosis-Specific Requirements</i> section [of the policy] ○ Coverage for testosterone cypionate (Depo-Testosterone®), testosterone enanthate, testosterone pellets (Testopel®), and testosterone undecanoate (Aveed®) is contingent on criteria in the <i>Diagnosis-Specific Requirements</i> section [of the policy] <p>Applicable Codes</p> <ul style="list-style-type: none"> ● Updated list of applicable HCPCS codes to reflect annual edits: <ul style="list-style-type: none"> ○ Added J1073 ○ Removed S0189 <p>Supporting Information</p> <ul style="list-style-type: none"> ● Added <i>CMS</i> section ● Updated <i>References</i> section to reflect the most current information ● Archived previous policy version IEXD0076.06

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, 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.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Benefit 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.