

testosterone cypionate (Azmiro)

Commercial Medical Benefit Drug Policy

Place of Service

Home Infusion

Office Administration

Outpatient Facility Infusion Administration

Drug Details

USP Category: HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)

Mechanism of Action: Endogenous androgen

HCPCS:

J1072:Injection, testosterone cypionate (azmiro), 1 mg

How Supplied:

- 200 mg/mL 1 single-dose vial
- 200 mg/mL 1 single-dose prefilled syringe

Condition(s) listed in policy (see coverage criteria for details)

- Testosterone Replacement

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

Coverage Criteria

The following condition(s) require Prior Authorization/Preservice.

Testosterone Replacement

Meets medical necessity if all the following are met:

1. Being used for male hypogonadism or testosterone replacement therapy for transgender patient
2. Intolerance or contraindication to generic IM testosterone cypionate formulation not expected with Azmiro

Covered Doses:

Up to 400 mg given by intramuscular injection every two weeks

Coverage Period:

Yearly based on continued response to therapy

testosterone cypionate (Azmiro)

Effective: 04/01/2025

Page 1 of 2

ICD-10:

E29.1, F64.0, F64.1, F64.8, F64.9

References

1. Azmiro (testosterone cypionate). Prescribing Information. Azurity Pharmaceuticals, Inc., Woburn, MA: 5/2024.

Review History

Date of Last Annual Review: 1Q2025

Changes from previous policy version:

- HCPCS: Added J1072, effective 4/1/2025

Blue Shield of California Medication Policy to Determine Medical Necessity

Reviewed by P&T Committee