ANABOLIC STEROIDS/ANDROGENS PA SUMMARY

PREFERRED	Anadrol-50, Danazol, Fluoxymesterone, Methitest, Oxandrolone, Testosterone Cypionate Injection, Testosterone Enanthate Injection
NON-PREFERRED	Android, Testred

LENGTH OF AUTHORIZATION: Varies

NOTE: All preferred and non-preferred agents require prior authorization. See PA criteria labeled "Topical Testosterone" for topical products.

The criteria details below are for the outpatient pharmacy program. *If an injectable medication is being administered in a physician's office, then the criteria information below does not apply. Instead, the physician's office must bill this drug through the DCH physician's injectable program and not the outpatient pharmacy program. Information regarding the physician's injectable program can be located at www.mmis.georgia.gov.*

PA CRITERIA:

For Anadrol-50

- Approvable for the following diagnoses: anemia caused by deficient red blood cell production, acquired or congenital aplastic anemia, myelofibrosis, hypoplastic anemia due to administration of myelotoxic drugs
- Also approvable for HIV or AIDS wasting when significant weight loss is documented in members currently receiving nutritional support

For Danazol

- Approvable for the following diagnoses: endometriosis, fibrocystic breast disease, hereditary angioedema

For Fluoxymesterone, Methyltestosterone (Android, Methitest, Testred), Testosterone Cypionate or Enanthate Injection

- Approvable in male members 12 years of age or older for the following diagnoses: primary hypogonadism, secondary hypogonadism, or delayed male puberty; Physician should submit documentation of low serum testosterone level.
- Approvable in female members for the diagnosis of metastatic breast cancer
- In addition, for Android and Testred, physician should submit a written letter of medical necessity stating the reason(s) that Methitest is not appropriate for the member.

For Oxandrolone

- Approvable for the following diagnoses when significant weight loss is documented in members currently receiving nutritional support: protein catabolism due to prolonged corticosteroid use, HIV or AIDS wasting, or failure to maintain or gain weight in the past 6 months due to extensive surgery, chronic infections, or severe trauma

- Approvable for short stature associated with Turner's Syndrome in members who have had an inadequate response to growth hormone
- Approvable for bone pain related to osteoporosis

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **SXC Health Solutions at 1-866-525-5827.**

PA and Appeal Process:

- For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on "prior approval process".

Quantity Level Limitations:

- For online access to the current Quantity Level Limits please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.