GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# GEORGIA MEDICAID FEE-FOR-SERVICE
# ANDROGENIC AGENTS, TOPICAL PA SUMMARY

| Preferred | Non-Preferred |
|---|---|
| Androderm (testosterone transdermal patch)<br>Androgel 1% and 1.62% (testosterone transdermal packet and pump) | Striant (testosterone buccal system)<br>Testosterone transdermal gel 1%, 2% generic (generic Fortesta, Testim, Vogelxo)<br>Testosterone transdermal solution generic |

**LENGTH OF AUTHORIZATION:** 6 months

**NOTE:** Preferred and non-preferred products require prior authorization.

**PA CRITERIA:**

*Androderm and Androgel*

- Approvable for male members 18 years of age or older with a diagnosis of primary or secondary hypogonadism whose serum testosterone is lower than 300 ng/dL confirmed by 2 laboratory blood levels conducted on separate days each in the morning.

*Striant, Testosterone Transdermal Gel Generic (generic Fortesta, Testim, Vogelxo) and Testosterone Transdermal Solution Generic*

- Must meet the criteria above and prescriber must submit a written letter of medical necessity stating the reasons the preferred products, brand Androderm and brand Androgel, are not appropriate for the member.

**EXCEPTIONS:**

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

**PREFERRED DRUG LIST:**

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

**PA AND APPEAL PROCESS:**

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

**QUANTITY LEVEL LIMITATIONS:**

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.