GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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

Preferred	Non-Preferred
Androgel 1.62% (testosterone transdermal gel pump) Testosterone transdermal gel pump 1.62% generic	Natesto (testosterone nasal gel) Testosterone transdermal gel 1%, 2% generic (generic Fortesta, Testim, Vogelxo) Testosterone transdermal solution generic

LENGTH OF AUTHORIZATION: 6 months

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

PA CRITERIA:

Androgel 1.62% and Testosterone Transdermal Gel Pump 1.62% Generic

- 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.

Natesto, 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 Androgel 1.62% and testosterone 1.62% generic, 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.