



**TOPICAL TESTOSTERONE PA SUMMARY**

<b>PREFERRED</b>	Androderm, Androgel 1% packets, 1% pump, 1.62% pump
<b>NON-PREFERRED</b>	Androgel 1.62% packets, Axiron, Fortesta, Testim

**LENGTH OF AUTHORIZATION:** 6 months

**PA CRITERIA:***For Androderm*

- ❖ Approvable for male members aged 15 years or older with a diagnosis of primary hypogonadism (congenital or acquired) or secondary hypogonadism (congenital or acquired).

*For Androgel 1% (packets or pump) or 1.62% pump*

- ❖ Approvable for male members 18 years or older with a diagnosis of primary hypogonadism (congenital or acquired) or secondary hypogonadism (congenital or acquired).

*For Androgel 1.62% packets, Axiron, Fortesta, and Testim*

- ❖ In addition to meeting Androgel preferred product criteria above, prescriber should submit a written letter of medical necessity stating the reason(s) that Androgel 1% (pump or packets) or 1.62% pump cannot be used.

**EXCEPTIONS:**

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

**PA and APPEAL PROCESS:**

- ❖ For online access to the PA process please go to [www.mmis.georgia.gov/portal](http://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 Limit please go to [www.mmis.georgia.gov/portal](http://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.