Missouri Pharmacy Program – Preferred Drug List

Androgenic Agents – Topical

Effective 12/31/2008
Revised 7/11/2019

Preferred Agents

- Androderm® Gel Patch
- **Depo®-Testosterone**
- **Testosterone Cypionate**
- **Testosterone Enanthate**
- Testosterone 1.62% Pump (gen AndroGel® 1.62% Pump)

Non-Preferred Agents

- AndroGel® Pack
- **AndroGel® 1% Pump**
- AndroGel® 1.62% Pump
- **Aveed®**
- Fortesta®
- **Methitest Tab™**
- **Methyltestosterone Cap**
- **Striant®**
- Testim ®
- **Testopel®**
- Testosterone 1% Pump (gen AndroGel® 1% Pump)
- Testosterone Gel (gen Fortesta®)
- Testosterone Gel Pump (gen Axiron®)
- Testosterone Transdermal (gen Testim®)
- Testosterone Gel Packet
- Vogelxo® Gel/Pump/Packet
- **Xyosted™**

Approval Criteria

- Failure to achieve desired therapeutic outcomes with trial on **3** or more preferred agents
  - Documented trial period for preferred agents
  - Documented ADE/ADR to preferred agents

Denial Criteria

- Therapy will be denied if no approval criteria are met
- Lack of adequate trial on required preferred agents
- Drug Prior Authorization Hotline: (800) 392-8030