



Missouri Pharmacy Program – Preferred Drug List



Androgenic Agents – Topical

Effective 12/31/2008

Revised 07/12/2018

Preferred Agents

- Androderm® Gel Patch
- AndroGel® Pump

Non-Preferred Agents

- **AndroGel® Packet**
- Axiron® Solution (discontinued)
- Fortesta® Gel
- Natesto® Nasal Gel
- Testim® Gel
- Testosterone Gel/Pump/Soln
- Testosterone Gel Packet
- Vogelxo® Gel/Pump/Package

Approval Criteria

- Failure to achieve desired therapeutic outcomes with trial on 2 or more preferred agents
 - Documented trial period for preferred agents
 - Documented ADE/ADR to preferred agents
- Documented compliance on current therapy regimen

Denial Criteria

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