



Missouri Pharmacy Program – Preferred Drug List



Topical Androgenic Agents

Effective 12/31/2008

Revised 10/06/2011

Preferred Agents

- Androderm®
- Androgel®

Non-Preferred Agents

- Testim®
- **Fortesta®**
- **Axiron®**

<u>Approval Criteria</u>	<u>Denial Criteria</u>
Failure to achieve desired therapeutic outcomes with trial on 2 or more preferred agents	Therapy will be denied if no approval criteria are met
Documented trial period for preferred agents	Lack of adequate trial on required preferred agents
Documented ADE/ADR to preferred agents	
Documented compliance on current therapy regimen	Drug Prior Authorization Hotline: (800) 392-8030