HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

HORMONE THERAPY FOR GENDER DYSPHORIA

Testosterone products, estradiol products

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 855-856-5694

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ testosterone products ☐ estradiol products ☐ anti-androgens ☐ leuprolide

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
GENDER DYSPHORIA IN CHILDREN/ADOLESCENTS			
1. Is the member <18 years of age?	☐	☐	
2. Was the member diagnosed with gender dysphoria prior to January 28, 2023?	☐	☐	**Please provide documentation**
3. Does documentation demonstrate that the provider has been treating the member for gender dysphoria for at least 6 months?	☐	☐	**Please provide documentation**
4. Has a health evaluation been completed by a medical health professional that includes the following: • the medical health professional is different from the hormonal transgender treatment provider • has a transgender treatment certification • documentation of history of at least 3 therapy sessions with the member • documentation of all mental health diagnoses and any significant life events that may be contributing to the member's diagnoses	☐	☐	**Please provide documentation**
5. Has the member experienced persistent, well documented gender dysphoria/gender incongruence including a marked	☐	☐	**Please provide documentation**

incongruence between one's experienced/expressed gender and natal gender of at least 6 months in duration?			
6. Does documentation show at least two of the following: • Marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics • Strong desire to rid of one's primary and/or secondary sex characteristics • Strong desire for the primary and/or secondary sex characteristics of other gender • Strong desire to be or be treated as the other gender • Strong conviction that one has the typical feelings and reactions of the other gender	☐	☐	**Please provide documentation**
7. Is the requesting provider an endocrinologist or physician who is experienced in hormonal therapy treatments in pediatric and adolescent patients, or in consultation with one?	☐	☐	
8. Are baseline laboratory values before hormonal transgender initiation available (e.g., for estradiol levels in female to male, or testosterone levels in males to female)?	☐	☐	**Please provide documentation**
9. Is there a monitoring plan in place? (e.g. evaluating the patient every 3 months in the first year of hormone therapy, testosterone/estradiol levels, hematocrit levels)	☐	☐	**Please provide documentation**
10. Does documentation show the following has been discussed with the member and parent/guardian: • reproductive health counseling • risks/benefit and expectations of hormone therapy and monitoring plan • other applicable preventive screenings	☐	☐	**Please provide documentation**
11. Does documentation include written consent from the member and the member's parent/guardian, unless the member is emancipated?	☐	☐	**Please provide documentation**
12. If the request is for leuprolide, does documentation show Tanner stage ≥2?	☐	☐	**Please provide documentation**
13. If the request is for leuprolide, is the request for Eligard?	☐	☐	**If no, clinical documentation must include a medical reason why the member cannot use the preferred agent Eligard**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation demonstrate a positive clinical response to hormones?	☐	☐	**Please provide documentation**
3. Has the member's mental health status been reassessed and appropriately managed?	☐	☐	**Please provide documentation**
4. Are there current laboratory hormone levels and any other relevant monitoring values?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-150
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024