HEALTH | CHOICE
UTAH

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 Health Choice Utah Prior Authorization Department at 385-425-4052.

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 assistance: 385-425-5094

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 patient 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 provider providing the hormonal transgender treatment • has a transgender treatment certification • documentation of the diagnosis of gender dysphoria	☐	☐	**Please provide documentation**
5. 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?	☐	☐	
6. Does documentation include written consent from the member and the member's parent/guardian, unless the member is emancipated?	☐	☐	**Please provide documentation**
7. If the request is for leuprolide, does documentation show Tanner stage ≥2?	☐	☐	**Please provide documentation**

8. 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**
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:			

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Policy: PHARM-HCU-150
Origination Date: 03/09/2023
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024