

HEALTHY U MEDICAID

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 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

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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Was the member diagnosed with gender dysphoria prior to January 28, 2023?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does documentation demonstrate that the provider has been treating the patient for gender dysphoria for at least 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member experienced persistent, well documented gender dysphoria/gender incongruence including a marked incongruence between one's experienced/expressed gender and natal gender of at least 6 months in duration?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does documentation show at least two of the following: <ul style="list-style-type: none"> • 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 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

<ul style="list-style-type: none"> Strong conviction that one has the typical feelings and reactions of the other gender 			
6. 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?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Is the member's Tanner Score ≥ 2 ?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
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)?	<input type="checkbox"/>	<input type="checkbox"/>	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)	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation demonstrate a positive clinical response to hormones?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member's mental health status been reassessed and appropriately managed?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Are there current laboratory hormone levels and any other relevant monitoring values?	<input type="checkbox"/>	<input type="checkbox"/>	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:			

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Policy: PHARM-HU-150
 Origination Date: 03/09/2023
 Reviewed/Revised Date: 03/15/2023
 Next Review Date: 03/15/2024
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