UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Hormone Therapy for Gender Dysphoria

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Gender Dysphoria Diagnosis [1,2]

1. Does the patient have a diagnosis of Gender Dysphoria marked by 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? (Must meet 2 of the following) ❑ **Yes** ❑ **No**
   - ☐ 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

Criteria for Approval in Adults: (*See below for PA in Minors*)

2. Is the patient 18 years of age or older? ❑ **Yes** ❑ **No**
3. Does the patient have the capacity to make a fully informed decision and provide consent for treatment? (minimum of 18 years of age) ❑ **Yes** ❑ **No**
4. Has the provider included documentation showing they have assessed and treated any physical or mental health if needed? ❑ **Yes** ❑ **No**
5. Has the provider discussed risks/benefits and expectations of hormone therapy (virilization, feminization or development of adverse reactions)? ❑ **Yes** ❑ **No**
6. Is there a documented monitoring plan, including the following:? ❑ **Yes** ❑ **No**

   Male to Female
   - ☐ Testosterone level for suppression: below upper limit of normal female range (<50 ng/dL)
   - ☐ Estradiol levels within premenopausal female range but below supraphysiologic levels (100-200 pg/dL)

   Female to Male

- ☐ Testosterone level: maintain levels within normal male range and avoid supraphysiological levels
- ☐ Hematocrit level: maintain level <50%; discontinue therapy if hematocrit exceeds 54%

7. Has the provider performed other applicable preventative screenings, such as cancer, osteoporosis *(baseline bone-mineral density test)*, etc.? ❑ **Yes** ❑ **No**

Criteria for Approval in Minors

8. Does the treating provider attest that they have completed at least 40 hours of education related to transgender health care for minors from an approved organization and received the "Transgender Treatment Certification: issued by the Division of Professional Licensing? ❑ **Yes** ❑ **No**

Additional Criteria[1,2] (*All* of the following criteria must be met)

9. Is the patient 18 years of age or less? ❑ **Yes** ❑ **No**
10. Is the hormonal treatment being prescribed by or in consultation with an endocrinologist or physician who is experienced in hormonal therapy treatments in pediatric and adolescent patients? ❑ **Yes** ❑ **No**
11. Was the patient diagnosed with gender dysphoria prior to January 28, 2023? ❑ **Yes** ❑ **No**
    Documentation demonstrates the date of diagnosis: _____
12. Has the provider included documentation demonstrating that the provider has been treating the patient for gender dysphoria for at least 6 months? ❑ **Yes** ❑ **No**
13. Has the provider included documentation showing they have assessed and treated any physical or mental health if needed? ❑ **Yes** ❑ **No**
14. Has the provider included documentation showing they have discussed alternative treatments or behavioral interventions for gender dysphoria? ❑ **Yes** ❑ **No**
15. Has the patient reached Tanner stage 2 of puberty *(if requesting gonadotropin releasing hormone as puberty blocker)*? ❑ **Yes** ❑ **No**
16. Has the provider included documentation of health evaluation by a mental health professional that includes ALL of the following:? ❑ **Yes** ❑ **No**
    - ☐ The mental health professional is different from the provider providing the hormonal transgender treatment
    - ☐ Has a transgender treatment certification
    - ☐ Has documentation of a history of at least 3 therapy sessions with the patient
    - ☐ Has documentation of all mental health diagnoses and any significant life events that may be contributing to the diagnoses of the patient
    - ☐ Has documentation that the patient has 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 (Must meet 2 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
17. Has the provider submitted laboratory values at baseline before hormonal transgender initiation? (select applicable option) ❑ **Yes** ❑ **No**
    - ☐ Estradiol levels in females; **OR**
    - ☐ Testosterone levels in males
18. Has the provider documented a monitoring plan, if applicable? ❑ **Yes** ❑ **No**

Male to Female

- ☐ Testosterone level
- ☐ Estradiol level

Female to Male

- ☐ Testosterone level
- ☐ Hematocrit level

19. Has the provider submitted documentation showing they have discussed with the patient and patient/guardian all of the following? ❑ **Yes** ❑ **No**
    - ☐ Reproductive health counseling
    - ☐ Risks/benefits and expectations of hormone therapy and monitoring plan
    - ☐ Other applicable preventative screenings
20. Has the provider submitted documentation of written consent from the patient and the patient's parent or guardian, unless the patient is emancipated? ❑ **Yes** ❑ **No**

Reauthorization Criteria:

1. Has the provider submitted updated chart notes demonstrating the patient has had a positive clinical response to hormones? ❑ **Yes** ❑ **No**
2. Has the patient had a reassessment of appropriate management of the patient's mental health status? ❑ **Yes** ❑ **No**
3. Has the provider submitted laboratory hormone levels and any other relevant monitoring values? ❑ **Yes** ❑ **No**
    - ☐ Male to Female: testosterone and estradiol
    - ☐ Female to Male: testosterone and hematocrit

Initial Authorization: Up to one (1) year
Reauthorization: Up to one (1) year

References:

1) Wylie C Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D Safer, Vin Tangpricha, Guy G T'Sjoen, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, The Journal of Clinical Endocrinology & Metabolism, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903, https://doi.org/10.1210/jc.2017-01658

2) World Professional Association for Transgender Health.Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. 2022. Available at: **https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644**
3) American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. 2022

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date

Transgender females	
Estrogen Therapy	
Oral estradiol	2.0-6.0 mg/day
Transdermal estradiol path (new patch placed every 3-5 days)	0.025-0.2 mg/day
Parenteral estradiol valerate or cypionate	• 5-30 mg IM every 2 weeks • 2-10 mg IM every week
Anti-androgens	
Spironolactone	100-300 mg/day
Transgender males	
Testosterone Therapy	
Parenteral testosterone enanthate or cypionate	100–200 mg sequentially IM every 2 weeks or SC 50% per week
Parenteral undecanoate (non-preferred product)	1,000 mg initially, followed by an injection at 6 weeks then at 12-week intervals
Transdermal testosterone gel 1.6%	50-100 mg/day
Transdermal testosterone patch	2.5-7.5 mg/day

Abbreviations: IM, intramuscularly; SC, subcutaneously.

References

1) Wylie C Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D Safer, Vin Tangpricha, Guy G T'Sjoen, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, The Journal of Clinical Endocrinology & Metabolism, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903, https://doi.org/10.1210/jc.2017-01658