Gender Affirming Medications Prior Authorization Form

Maryland Medicaid Pharmacy Program

Fax#: (877) 270-3298 | Phone#: (866) 827-2710

Incomplete forms will not be reviewed.

Date: _____

Patient's Information:

Name: _____ DOB: _____

Maryland Medicaid Number: _____ Sex Assigned at birth: ☐ Male ☐ Female

Identifying Gender: _____ Weight: _____ Height: _____ Allergies: _____

Prescriber's Information:

Name: _____ Specialty: _____ NPI#: _____

Phone#: _____ Fax#: _____

Contact Person for this Request:

Name: _____ Phone#: _____

Diagnosis Requested:

Diagnosis: _____ Diagnosis Date: _____

Requested Drug Information:

- ☐ Triptodur Kit ® (triptorelin kit)
- ☐ Trelstar ® (triptorelin pamoate for injectable suspension)
- ☐ Propecia tablets ® (finasteride)
- ☐ Other: _____

☐ New Request ☐ Refill

Strength: _____ Quantity: _____

Directions: _____

Clinical Information:

Clinical documentation supporting the following must be submitted:

1. Patients ≥18 years old:

- ☐ Documentation of medical necessity for Gender affirming Care from a Somatic Healthcare professional (e.g. primary care) or Mental Healthcare Professional who has competencies in the assessment of transgender and gender diverse population is required.
- ☐ Height and weight every three months within the first year then every 6 months thereafter.
- ☐ Testosterone levels every three months within the first year then every 6 months thereafter.
- ☐ Renal function, liver function, lipids, glucose, insulin, hemoglobin A1C within 1 year of approval.

2. Patients < 18 years old:

- ☐ Documentation of medical necessity for Gender affirming Care from a Somatic Healthcare Professional (e.g. primary care) or a Mental Health Professional who is a member of the multidisciplinary team that has competencies in the assessment of transgender and gender diverse population is required.
- ☐ Height and weight every three months within the first year then every 6 months thereafter.
- ☐ Testosterone levels every three months within the first year then every 6 months thereafter.
- ☐ Renal function, liver function, lipids, glucose, insulin, hemoglobin A1C within 1 year of approval.

3. Initial Request Requirements:

   - ☐ Provider has attached clinical notes indicating treatment plan of the proposed therapy.
   - ☐ Provider attestation that all FDA precautions/warnings, contraindications to treatment, and any Black Box Warnings have been considered.
   - ☐ Attestation of the discontinuation of all medications that are contraindicated in concurrent use.

4. Length of Authorization:

   Gender Affirming medications will have an initial approval of **3 months** and renewal approval of **6 months.** Please refer to clinical criteria for further details at: https://health.maryland.gov/mmcp/pap/pages/Clinical-Criteria.aspx

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature.

Prescriber's Signature: _____ **Date:** _____