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NYRx the Medicaid Pharmacy Program

Pubertal Suppressants (GnRH Agonists)/Hormone Replacement Therapy for Treatment of Gender Dysphoria

Prior Authorization Worksheet

Fax Number: 1-800-268-2990

Processing may be delayed if information submitted is illegible or incomplete. This form must be completed by the prescriber, not their authorized agent.

ENROLLEE INFORMATION

Enrollee's Last Name:

Enrollee's First Name:

Date of Birth:

Enrollee's Medicaid ID (2 letters, 5 numbers, 1 letter):

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

Board Certified Specialty:

Prescriber's Street Address:

City:

State:

Zip Code

Prescriber's Phone Number:

Prescriber's Fax Number:

REQUESTED DRUG INFORMATION

Drug Name: _____ **Drug Strength:** _____

Quantity: _____ **Refills:** _____

Directions: _____

New Prescription: ☐ Yes ☐ No If **NO**, date therapy was initiated: _____

Revision Date: 03/17/2025

Enrollee's Last Name: **Enrollee's First Name:**

DIAGNOSIS AND DRUG INFORMATION

1. What is the diagnosis that requires treatment? _____

2. What drug are you requesting? (Please select one and provide specific drug name if applicable.)

Pubertal Suppressants (GnRH Agonists):

- ☐ Leuprolide acetate (Eligard®)
- ☐ Leuprolide acetate (Fensolvi®, Lupron Depot®, Lupron Depot-Ped®)
- ☐ Nafarelin acetate (Synarel®)
- ☐ Triptorelin pamoate (Triptodur®)

Hormone Replacement Therapy for Treatment of Gender Dysphoria:

- ☐ Conjugated estrogens
- ☐ Estradiol
- ☐ Testosterone cypionate (Depo®-Testosterone, Azmiro™)
- ☐ Testosterone enanthate
- ☐ Testosterone (AndroGel®) 1.62% gel and gel metered-dose pump
- ☐ Xyosted®

CLINICAL CRITERIA FOR PUBERTAL SUPPRESSANTS (GNRH AGONISTS) AND HORMONE REPLACEMENT THERAPY FOR TREATMENT OF GENDER DYSPHORIA

1. Does the individual meet the criteria for a diagnosis of gender dysphoria?
   ☐ Yes ☐ No
2. Has the individual experienced puberty to at least Tanner stage 2, and pubertal changes have resulted in an increase in gender dysphoria?
   ☐ Yes ☐ No
3. Does the individual suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment?
   ☐ Yes ☐ No
4. Does the individual have adequate psychological and social support during treatment?
   ☐ Yes ☐ No
5. Does the individual demonstrate knowledge and understanding of the expected outcomes of treatment with pubertal suppressants and hormone replacement therapy for treatment of gender dysphoria, as well as the medical and social risks and benefits of sex reassignment?
   ☐ Yes ☐ No

Enrollee's Last Name: **Enrollee's First Name:**

CLINICAL CRITERIA FOR PUBERTAL SUPPRESSANTS (GNRH AGONISTS) AND HORMONE REPLACEMENT THERAPY FOR TREATMENT OF GENDER DYSPHORIA (*CONTINUED*)

6. Please include any other clinical information to be considered during the authorization process. Requests for Hormone Replacement Therapy for individuals < 15 years of age, require a Letter of Medical Necessity **signed by the treating provider** and a copy of the individual's chart documenting the clinical criteria requirements listed in numbers 1–5 above. For more information refer to: NYRx Drug Class Coverage Overview: Pubertal Suppressants and Hormone Replacement Therapy for Treatment of Gender Dysphoria

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Fax Number: 1-800-268-2990
Prior Authorization Call Line: 1-877-309-9493
Billing Questions: 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.