Gateway Health
It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

# I. Requirements for Prior Authorization of Estrogens

## A. Prescriptions That Require Prior Authorization

Prescriptions for Estrogens that meet any of the following conditions must be prior authorized:

1. A non-preferred Estrogen. See the Preferred Drug List (PDL) for the list of preferred Estrogens at: https://papdl.com/preferred-drug-list.

## B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Estrogen, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Estrogen for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Does not have a history of a contraindication to the prescribed medication; **AND**

4. Has a history of therapeutic failure, contraindication, or intolerance of the preferred Estrogens; **AND**

5. For gender dysphoria, **both** of the following:

a. Is prescribed the Estrogen by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine
b. Is prescribed the Estrogen in a manner consistent with the current World Professional Association for Transgender Health standards of care for the health of transsexual, transgender, and gender nonconforming people;

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

## C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Estrogen. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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# ESTROGENS PRIOR AUTHORIZATION FORM

| | | | |
|---|---|---|---|
| ☐New request ☐Renewal request | # of pages: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | |
| Contact's phone number: | | NPI: | State license #: |
| LTC facility contact/phone: | | Street address: | |
| Beneficiary name: | | Suite #: | City/state/zip: |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

## CLINICAL INFORMATION

*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*

| | | |
|---|---|---|
| Drug requested: | Strength/concentration: | |
| Dosage form: | Package size: | |
| Dose/directions: | Quantity: | Refills: |
| Diagnosis *(submit documentation)*: | Dx code (*required*): | |

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|---|---|
| For a non-preferred Estrogen: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.* | ☐Yes – *Submit documentation.*<br>☐No |
| Is the requested medication prescribed for an indication that is supported by a drug reference, medical literature, and/or national treatment guidelines? | ☐Yes<br>☐No – *Submit medical literature supporting the use of the requested agent for the beneficiary's diagnosis.* |
| *If being treated for gender dysphoria:* Is the requested medication prescribed by or in consultation with an endocrinologist or medical provider with experience and/or training in transgender medicine? | ☐Yes ☐No *Submit documentation of consultation if applicable.* |
| *If being treated for gender dysphoria:* Is the requested medication prescribed in a manner consistent with current WPATH standards of care? | ☐Yes ☐No *Submit documentation.* |

## PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

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|---|---|
| Prescriber Signature: | Date: |