Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Estrogens

A. Prescriptions That Require Prior Authorization

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. For a non-preferred Estrogen, **all** of the following:

   a. Is prescribed the requested Estrogen for an indication that is consistent with the U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

   b. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

   c. Does not have a contraindication to the prescribed drug,

   d. **One** of the following:

      i. For a non-preferred systemic Estrogen, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred systemic Estrogens approved or medically accepted for the beneficiary's diagnosis
      ii. For a non-preferred vaginal Estrogen, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred vaginal Estrogens approved or medically accepted for the beneficiary's diagnosis;

   AND

2. 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 Transgender and Gender Diverse 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 *(form effective 7/6/2026)*

☐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:		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*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

1. For a non-preferred SYSTEMIC Estrogen:
☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred SYSTEMIC Estrogens (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

2. For a non-preferred VAGINAL Estrogen:
☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred VAGINAL Estrogens (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

3. For a diagnosis of GENDER DYSPHORIA:
☐The prescriber is an endocrinologist or medical provider with experience or training in transgender medicine
☐The drug is prescribed in a manner consistent with current WPATH standards of care

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**:

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