Gender Affirming Care

Included Products: nonformulary requests and quantity limit requests for gender affirming care.

Created: 11/09/23 *Revised:* 11/09/23 *Reviewed:* 11/09/23 *Updated:* 12/01/2023

Gender Affirming Care			
Initial Criteria		**If yes**	**If no**
1.	Is the request for a formulary drug that requires prior authorization (PA)?	Use that specific PA criteria/policy. This criteria does not apply.	Continue to #2.
2.	Is the request for a quantity limit for a formulary drug?	Continue to #5.	Continue to #3
3.	Has the provider submitted a statement that the requested product is medically necessary and plan preferred alternatives have been tried and failed or are not medically appropriate?	Continue to #4.	Request provider consider alternatives. If no response continue to #4
4.	Are there concerns with any of the following: whether the use is consistent with standards of care; OR the provider's statement of medical necessity would benefit from review from an independent specialist?	Plan to initiate an independent review and follow the decision from that reviewer.	Approve x requested duration.
5.	Are both of the following met a) the provider is using the most appropriate formulation for the clinical dosing (such as weekly vs twice weekly patches) AND b) has demonstrated higher doses are necessary to achieve therapeutic effect that cannot be met with other covered strengths?	Approve x requested duration.	Provide alternative dosage forms to achieve the intended request.