

**State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
Gender Affirming Hormone Therapy (GAHT) Products: Members Under 19 Years of Age**

Phone: 1-888-445-0497

ONE Drug Per Form ONLY – Use Black or Blue Ink

Fax: 1-888-879-6938

Member ID #: Patient Name: _____ DOB: _____
(NOT MEDICARE NUMBER)

Patient Address: _____

Provider DEA: Provider NPI:

Provider Name: _____ Phone: _____

Provider Address: _____ Fax: _____

Pharmacy Name: _____ Rx Address: _____ Rx phone: _____

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: NABP: NDC:

<u>Drug Name</u>	<u>Strength</u>	<u>Instructions</u>	<u>Dosage/Quantity</u>	<u>Days Supply</u>	<u>Refills</u>
					1 2 3 4 5

Applicable Products: (PA required for members under 19 years of age, preferred and non-preferred)

- Androgens: testosterone, testosterone cypionate, testosterone enanthate, testosterone undecanoate
- Estrogens: estradiol, estradiol valerate, estradiol vaginal, estradiol/norethindrone acetate
- Progestins: progesterone
- Antiandrogen (aldosterone antagonist): spironolactone
- GnRH analogues: leuprolide acetate (3-month depot, 6-month pediatric kit), histrelin acetate implant

Clinical Information Required:

1. Is the member under 19 years of age? ☐ Yes ☐ No
2. Is the member being prescribed this drug for one of the following diagnoses? *(check all that apply)*
 - ☐ F64.0 Transsexualism
 - ☐ F64.1 Gender identity disorder in adolescence and adulthood
 - ☐ F64.2 Gender identity disorder of childhood
 - ☐ F64.8 Other gender identity disorders
 - ☐ F64.9 Gender identity disorder, unspecified
 - ☐ Z87.890 Personal history of sex reassignment
 - ☐ None of the above

****This information allows MaineCare to identify the clinical purpose of the medication and determine the appropriate coverage and funding pathway.***

Certification to seek exception from chart documentation requirement:

I certify that (a) the information provided is accurate and complete to the best of my knowledge, and (b) that any required supporting medical record documentation is physically or electronically accessible and satisfies the explicitly posted relevant PDL criteria. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. As per MaineCare Benefits Manual, Chapter I, Sections 1.16 and 1.19, “sanctions” (including recouping payments previously made) “may be imposed by the Department against a provider submitting false information for the purpose of meeting prior authorization requirements.”

Provider Signature: _____ Date of Submission: _____

***MUST MATCH PROVIDER LISTED ABOVE**

OR

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____

***MUST MATCH PROVIDER LISTED ABOVE**