United Healthcare Community Plan

Gender Affirming Care (GAC) - Maryland
Prior Authorization Form

Please complete this **entire** form and fax it to **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.
Incomplete Forms will not be reviewed.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _______

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _________

Section B - Provider Information

First Name:		Last Name:		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

□ **Triptodur Kit® (triptorelin kit)** □ **Trelstar® (triptorelin pamoate for injectable suspension** □ **Propecia tablets® (finasteride)** □ **Other**	**Diagnosis:** ________________________________ ________________________________ **Diagnosis Date:** ____________________________
Strength:	**Quantity:**
Directions:	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure/discontinuation

Section E – Additional Information

United Healthcare Community Plan

Gender Affirming Care (GAC) - Maryland
Prior Authorization Form

Member First Name:	Member Last Name:	Member DOB:

Clinical and Drug Specific Information

INITIAL AND REAUTHORIZATIONS

☐ Individuals ≥ 18 years of age**:** Documentation of medical necessity for Gender affirming Care from a Somatic Healthcare professional (e.g. primary care) or Mental Healthcare Professional who has competencies in the assessment of transgender and gender diverse population is required

☐ Individuals < 18 years of age: Documentation of medical necessity for Gender affirming Care from a Somatic Healthcare Professional (e.g. primary care) or a Mental Health Professional who is a member of the multidisciplinary team that has competencies in the assessment of transgender and gender diverse population is required

☐ Treatment plan and clinical notes attached to support request

Prescriber Attestation:

☐ All FDA precautions/warnings, contraindications to treatment, and any Black Box Warnings have been considered

☐ Discontinuation of all medications that are contraindicated in concurrent use

☐ Height and weight will be monitored every 3 months within the first year of treatment, then every 6 months

☐ Renal function, liver function, lipids, glucose, insulin, hemoglobin A1C will be monitored within 1 year of approval

☐ Testosterone levels will be monitored every three months within the first year then every 6 months thereafter

☐ Individual will remain active in psychological and social support program

☐ Individual has knowledge and understanding of the expected outcomes of treatment

Laboratory Results (**Reauthorization Only**)

☐ Testosterone levels attached (every 3 months within the first year, then every 6 months)

☐ Renal function, liver function, lipids, glucose, insulin, hemoglobin A1C within 1 year of approval and annually thereafter

Authorization (Initial and Reauthorization): 12 months

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge. UHC and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature.

Provider Signature: ____ **Date:** ____________________

Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.