



**NYRx the Medicaid Pharmacy Program  
Pubertal Suppressants (GnRH Agonists) / Hormone Replacement  
Therapy for Treatment of Gender Dysphoria  
Prior Authorization Worksheet**

**Fax Number: 1-800-268-2990**

Processing may be delayed if information submitted is illegible or incomplete. This form must be completed by the prescriber, not their authorized agent.

**ENROLLEE INFORMATION**

**Enrollee's Last Name:**

**Enrollee's First Name:**

\_\_\_\_\_

\_\_\_\_\_

**Date of Birth:**

**Enrollee's Medicaid ID (2 letters, 5 numbers, 1 letter):**

\_\_\_\_\_

\_\_\_\_\_

**PRESCRIBER INFORMATION**

**Prescriber's Last Name:**

**Prescriber's First Name:**

\_\_\_\_\_

\_\_\_\_\_

**National Provider Identifier (NPI) Number:**

**Board Certified Specialty:**

\_\_\_\_\_

\_\_\_\_\_

**Prescriber's Street Address:**

\_\_\_\_\_

**City:**

**State:**

**Zip Code**

\_\_\_\_\_

\_\_\_\_\_

**Prescriber's Phone Number:**

**Prescriber's Fax Number:**

\_\_\_\_\_

\_\_\_\_\_

**REQUESTED DRUG INFORMATION**

**Drug Name:** \_\_\_\_\_ **Drug Strength:** \_\_\_\_\_

**Quantity:** \_\_\_\_\_ **Refills:** \_\_\_\_\_

**Directions:** \_\_\_\_\_

**New Prescription:**  Yes  No **If NO, date therapy was initiated:** \_\_\_\_\_

Enrollee's Last Name:

Enrollee's First Name:

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**DIAGNOSIS AND DRUG INFORMATION**

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1. What is the diagnosis that requires treatment? \_\_\_\_\_

2. What drug are you requesting? (Please select one and provide specific drug name if applicable.)

**Pubertal Suppressants (GnRH Agonists):**

- Leuprolide acetate (Fensolvi®, Lupron®, Lupron Depot®, Lupron Depot-Ped®)
- Nafarelin acetate (Synarel®)
- Triptorelin pamoate (Triptodur®)

**Hormone Replacement Therapy for Treatment of Gender Dysphoria:**

- Androderm® patch
- Conjugated estrogens
- Estradiol
- Testosterone cypionate (Depo®-Testosterone)
- Testosterone enanthate
- Testosterone (AndroGel®) 1.62% gel & gel metered-dose pump
- Xyosted®

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**CLINICAL CRITERIA FOR PUBERTAL SUPPRESSANTS (GNRH AGONISTS) AND HORMONE REPLACEMENT THERAPY FOR TREATMENT OF GENDER DYSPHORIA**

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1. Does the individual meet the criteria for a diagnosis of gender dysphoria?  
 Yes    No
2. Has the individual experienced puberty to at least Tanner stage 2, and pubertal changes have resulted in an increase in gender dysphoria?  
 Yes    No
3. Does the individual suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment?  
 Yes    No
4. Does the individual have adequate psychological and social support during treatment?  
 Yes    No
5. Does the individual demonstrate knowledge and understanding of the expected outcomes of treatment with pubertal suppressants and hormone replacement therapy for treatment of gender dysphoria, as well as the medical and social risks and benefits of sex reassignment?  
 Yes    No

Enrollee's Last Name:

Enrollee's First Name:

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**CLINICAL CRITERIA FOR PUBERTAL SUPPRESSANTS (GNRH AGONISTS) AND HORMONE REPLACEMENT THERAPY FOR TREATMENT OF GENDER DYSPHORIA (*CONTINUED*)**

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6. Please include any other clinical information to be considered during the authorization process:

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Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

**Fax Number:** 1-800-268-2990

**Prior Authorization Call Line:** 1-877-309-9493

**Billing Questions:** 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit <http://newyork.fhsc.com> or call 1-877-309-9493.