Prior Authorization Request
Cross Gender Hormone Therapy (CGHT)
(MtF or FtM)

Patient Last Name:	**First Name:**	**CIN #**:	**Date Of Birth**:	**Patient Phone #:**
Primary Care Provider	**PCP Name**:	**Contact Phone #:**	**NPI #:**	
Services: *Please attach prescription*		**Allowed units**: 30 day supply (Up to 6 months)		
Diagnosis (ICD-9: 042, 302.50, 259.9)				
Initial Authorization Request Date:		**If Re-Authorization- Request Date CGHT Started:**		

Clinical Criteria
Please answer all of the following:

Criteria	Yes	No
Patient is age 18 years of age or older		
Estrogen Therapy- Patient legal gender marker is male		
Testosterone Therapy- Patient legal gender marker is female		
Patient has no medical contraindications for CGHT		
Patient had a Mental Health Evaluation a maximum of 3 months prior to the **initial** provision of therapy		

PLEASE FAX FORM TO EXPRESS SCRIPTS: 1-800-357-9577
If you have any questions, please call 1-800-753-2851