Clinical Policy: Estrogens

Reference Number: PHW.PDL.718
Effective Date: 01/01/2020
Last Review Date: 11/2024

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health & Wellness® that Estrogens are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Estrogens

A. Prescriptions That Require Prior Authorization

Prescriptions for Estrogens that meet any of the following conditions must be prior authorized:

1. A non-preferred Estrogen.

2. An Estrogen with a prescribed quantity that exceeds the quantity limit.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Estrogen, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For a non-preferred Estrogen, **all** of the following:

    a. Is prescribed the Estrogen for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication,
    b. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
    c. Does not have a contraindication to the prescribed medication,
    d. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Estrogens;

    AND

2. For gender dysphoria, **both** of the following:

    a. Is prescribed the Estrogen by or in consultation with an endocrinologist or

medical provider with experience and/or training in transgender medicine

b. Is prescribed the Estrogen in a manner consistent with the current World Professional Association for Transgender Health Standards of Care for the Health of Transgender and Gender Diverse People;

2. If a prescription for an Estrogen is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

   NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Estrogen. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member.

D. **Approval Duration: 12 months**

E. **References:**

1. Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. Int J Transgend Health. 2022 Sep 6;23(Suppl 1):S1-S259. doi: 10.1080/26895269.2022.2100644. PMID: 36238954; PMCID: PMC9553112.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021: policy revised according to DHS revisions effective 01/05/2021	11/2020
Q1 2022 annual review: no changes.	11/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024: policy revised according to DHS revisions effective 01/08/2024	11/2023
Q1 2025 annual review: no changes.	11/2024