

MEDICAL ASSISTANCE BULLETIN

ISSUE DATE November 13, 2023	EFFECTIVE DATE January 8, 2024	NUMBER *See below
SUBJECT Prior Authorization of Estrogens – Pharmacy Services		BY  Sally A. Kozak, Deputy Secretary Office of Medical Assistance Programs

IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: <https://www.dhs.pa.gov/providers/Providers/Pages/PROMISe-Enrollment.aspx>.

PURPOSE:

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Estrogens submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Estrogens will be utilized in the fee-for-service delivery system and by the MA managed care organizations (MCOs) in Physical Health HealthChoices and Community HealthChoices. Providers rendering services in the MA managed care delivery system should address any questions related to the prior authorization of Estrogens to the appropriate MCO.

BACKGROUND/DISCUSSION:

The Department of Human Services (Department) is updating the medical necessity guidelines for Estrogens to reflect the current title of the World Professional Association for

*01-23-39	09-23-38	27-23-29	33-23-36
02-23-27	11-23-27	30-23-30	
03-23-25	14-23-26	31-23-40	
08-23-42	24-23-35	32-23-25	

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs website at

<https://www.dhs.pa.gov/providers/Providers/Pages/Health%20Care%20for%20Providers/Contact-Information-for-Providers.aspx>.

Transgender Health Standards of Care for the Health of Transgender and Gender Diverse People. There are no other changes to the medical necessity guidelines.

The revisions to the guidelines to determine medical necessity of prescriptions for Estrogens were subject to public review and comment and subsequently approved for implementation by the Department.

PROCEDURE:

The procedures for prescribers to request prior authorization of Estrogens are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Estrogens) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs and products that require prior authorization.

ATTACHMENTS:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

RESOURCES:

Prior Authorization of Pharmaceutical Services Handbook – SECTION I
Pharmacy Prior Authorization General Requirements

<https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Pharmacy-Prior-Authorization-General-Requirements.aspx>

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines

<https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Clinical-Guidelines.aspx>

MEDICAL ASSISTANCE HANDBOOK
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

I. Requirements for Prior Authorization of Estrogens

A. Prescriptions That Require Prior Authorization

1. A non-preferred Estrogen. See the Preferred Drug List (PDL) for the list of preferred Estrogens at: <https://papdl.com/preferred-drug-list>.
2. An Estrogen with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx>.

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 beneficiary:

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;

AND

3. If a prescription for an Estrogen is for 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 the Quantity Limits Chapter.

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NOTE: If the beneficiary 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 beneficiary, 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 beneficiary.

D. 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.