

PRIOR AUTHORIZATION CRITERIA

BRAND NAME*
(generic)

PROPECIA
(finasteride)

ROGAINE (OTC)
(minoxidil)

Status: CVS Caremark® Criteria
Type: Initial Prior Authorization

REG
Ref # 5134-A

**Drugs that are listed in the target drug box include both brand and generic and all dosage forms and strengths unless otherwise stated. OTC products are not included unless otherwise stated.*

COVERAGE CRITERIA

Gender Affirming Treatment

Authorization may be granted when the requested drug is being prescribed for gender affirming treatment in a transgender or gender diverse (TGD) patient when the following criteria is met:

- The requested drug is medically necessary

DURATION OF APPROVAL (DOA)

- 5134-A: DOA: 12 months

REFERENCES

1. Washington SB 5313. November 2021.
2. Minnesota Administrative Bulletin 2021-3. December 2021.
3. Hawaii HB 2405. June 2022.
4. Oregon HB 2002. July 2023.
5. Illinois 2024-01 Bulletin. January 2024.
6. Maryland HB 283. May 2023.
7. Colorado CCR 702-4 Series 4-2: 4-2-62. January 2019.
8. New Hampshire Bulletin INS 20-033-AB. January 2020.
9. New York Ins. Law § 4902. June 2024.
10. 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;23(S1):S1-S258.
11. UCSF Gender Affirming Health Program, Department of Family and Community Medicine, University of California San Francisco. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People; 2nd edition. Deutsch MB, ed. June 2016. Available at: transcare.ucsf.edu/guidelines.
12. Health Care for Transgender and Gender Diverse Individuals. ACOG Committee Opinion No. 823. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2021;137:e75-88.

Written by: UM Development (JK)
Date Written: 03/2022
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Gender Affirming Care PA REG 5134-A UDR 04-2024 v2.docx

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MDC: REG

CRITERIA FOR APPROVAL

- | | | | |
|---|--|-----|----|
| 1 | Is the requested drug being prescribed for gender affirming treatment in a transgender or gender diverse (TGD) patient?
[If Yes, then go to 2. If No, then no further questions.] | Yes | No |
| 2 | Is the requested drug medically necessary?
[No further questions] | Yes | No |

Mapping Instructions			
	Yes	No	DENIAL REASONS
1.	Go to 2	Deny	<p>Your plan only covers this drug when it is used for certain health conditions. Your plan does not cover this drug for your health condition that your doctor told us you have. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Diagnosis]</p>
2.	Approve, 12 Months	Deny	<p>Your plan only covers this drug when it is medically necessary. We reviewed the information we had. Your request has been denied. Your doctor can send us any new or missing information for us to review. For this drug, you may have to meet other criteria. You can request the drug policy for more details. You can also request other plan documents for your review.</p> <p>[Short Description: Medically necessary]</p>