PRIOR AUTHORIZATION CRITERIA

DRUG CLASS

ESTROGEN (ALL PRODUCTS)

PROGESTIN (ALL PRODUCTS)

Status: Client Requested Criteria
Type: Initial Prior Authorization ***Ref # C24441-A***

CRITERIA FOR APPROVAL

1	Is the requested drug being prescribed for treatment for, or related to, sex transformations or sexual dysfunctions or inadequacies? [If no, then documentation of diagnosis is required for approval.] [Tech Note: For drug coverage approval, diagnosis cannot be for, or related to, sex transformations or sexual dysfunctions or inadequacies.]	Yes	No

Mapping Instructions		
	Yes	**No**
1.	Deny	Approve, 12 months

REFERENCES
N/A

Written by: UM Development (JK)
Date Written: 11/2022
Revised:
Reviewed: Medical Affairs: (DC) 12/2022

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

_____ _____
Signature Date

_____
Client Name