

Texas Prior Authorization Program Clinical Criteria

Drug/Drug Class

Hormonal Therapy Agents

This criteria was recommended for review by VDP to ensure appropriate and safe utilization

Clinical Information Included in this Document

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic:** a description of how the prior authorization request will be evaluated against the clinical criteria rules
- **Logic diagram:** a visual depiction of the clinical criteria logic
- **Supporting tables:** a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes); provided when applicable
- **References:** clinical publications and sources relevant to this clinical criteria

Note: Click the hyperlink to navigate directly to that section.

Revision Notes

Initial publication and presentation to the DUR Board



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Drugs Requiring Prior Authorization

The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization	
Label Name	GCN
ANDRODERM 2 MG/24 HR PATCH	30796
ANDRODERM 4 MG/24 HR PATCH	29171
ANDROGEL 1.62% PUMP	29905
CLIMARA 0.025 MG/DAY PATCH	28848
CLIMARA 0.0375 MG/DAY PATCH	20069
CLIMARA 0.05 MG/DAY PATCH	28845
CLIMARA 0.06 MG/DAY PATCH	20068
CLIMARA 0.075 MG/DAY PATCH	28853
CLIMARA 0.1 MG/DAY PATCH	28844
CLIMARA PRO PATCH	20849
DELESTROGEN 100 MG/5 ML VIAL	10690
DELESTROGEN 200 MG/5 ML VIAL	10694
DELESTROGEN 50 MG/5 ML VIAL	10692
DEPO-ESTRADIOL 5 MG/ML VIAL	10660
DEPO-ESTRADIOL 5 MG/ML VIAL	10660
DEPO-TESTOSTERONE 1,000MG/10ML	10191
DEPO-TESTOSTERONE 200 MG/ML	10194
DIVIGEL 0.25 MG GEL PACKET	98558
DIVIGEL 0.5 MG GEL PACKET	26659
DIVIGEL 1 MG GEL PACKET	10777
DOTTI 0.025 MG PATCH	28842
DOTTI 0.0375 MG PATCH	28846
DOTTI 0.05 MG PATCH	28840
DOTTI 0.075 MG PATCH	28843
DOTTI 0.1 MG PATCH	28841
ELIGARD 22.5 MG SYRINGE KIT	18155
ELIGARD 30 MG SYRINGE KIT	19219
ELIGARD 45 MG SYRINGE KIT	24301
ELIGARD 7.5 MG SYRINGE KIT	17377
ESTRACE 0.5 MG TABLET	10772

Drugs Requiring Prior Authorization	
Label Name	GCN
ESTRACE 1 MG TABLET	10770
ESTRACE 2 MG TABLET	10771
ESTRADIOL 0.025 MG PATCH(1/WK)	28848
ESTRADIOL 0.025 MG PATCH(2/WK)	28842
ESTRADIOL 0.0375MG PATCH(1/WK)	20069
ESTRADIOL 0.0375MG PATCH(2/WK)	28846
ESTRADIOL 0.05 MG PATCH (1/WK)	28845
ESTRADIOL 0.05 MG PATCH (2/WK)	28840
ESTRADIOL 0.06 MG PATCH (1/WK)	20068
ESTRADIOL 0.075 MG PATCH(1/WK)	28853
ESTRADIOL 0.075 MG PATCH(2/WK)	28843
ESTRADIOL 0.1 MG PATCH (1/WK)	28844
ESTRADIOL 0.1 MG PATCH (2/WK)	28841
ESTRADIOL 0.1% (0.25MG) GEL PK	98558
ESTRADIOL 0.1% (0.5MG) GEL PKT	26659
ESTRADIOL 0.1% (0.75MG) GEL PK	45909
ESTRADIOL 0.1% (1 MG) GEL PKT	10777
ESTRADIOL 0.1% (1.25MG) GEL PK	47491
ESTRADIOL 1 MG TABLET	10770
ESTRADIOL 2 MG TABLET	10771
ESTRADIOL VALERATE 100 MG/5 ML	10690
ESTRADIOL VALERATE 200 MG/5 ML	10694
ESTRADIOL VALERATE 50 MG/5 ML	10692
FENSOLVI 45 MG SYRINGE KIT	47966
FORTESTA 10 MG GEL PUMP	98317
LEUPROLIDE 2WK 14 MG/2.8 ML KIT	84597
LEUPROLIDE DEPOT 22.5 MG VIAL	84594
LUPRON DEPOT 11.25 MG 3MO KIT	84350
LUPRON DEPOT 22.5 MG 3MO KIT	84593
LUPRON DEPOT 3.75 MG KIT	80254
LUPRON DEPOT 45 MG 6MO KIT	30083
LUPRON DEPOT 7.5 MG KIT	29894
LUPRON DEPOT-4 MONTH KIT	84598
LUPRON DEPOT-PED 11.25 MG 3MO	30357
LUPRON DEPOT-PED 11.25 MG KIT	13172
LUPRON DEPOT-PED 15 MG KIT	13174
LUPRON DEPOT-PED 30 MG 3MO KIT	30356

Drugs Requiring Prior Authorization	
Label Name	GCN
LUPRON DEPOT-PED 45 MG 6MO KIT	54034
LUPRON DEPOT-PED 7.5 MG KIT	13173
MENOSTAR 14 MCG/DAY PATCH	22759
METHYLTESTOSTERONE 10 MG CAP	10380
NATESTO NASAL 5.5 MG/0.122 GM	38079
TESTIM 1% (50 MG) GEL	97089
TESTOSTERON ENAN 1,000 MG/5 ML	10253
TESTOSTERONE 1% (25MG/2.5G) PK	47851
TESTOSTERONE 1% (50 MG/5 G) PK	47852
TESTOSTERONE 1.62% (2.5 G) PKT	33453
TESTOSTERONE 1.62% GEL PUMP	29905
TESTOSTERONE 1.62%(1.25 G) PKT	33452
TESTOSTERONE 10 MG GEL PUMP	98317
TESTOSTERONE 12.5 MG/1.25 GRAM	23141
TESTOSTERONE 30 MG/1.5 ML PUMP	29647
TESTOSTERONE 50 MG/5 GRAM GEL	97089
VIVELLE-DOT 0.075 MG PATCH	28843
VIVELLE-DOT 0.1 MG PATCH	28841
VOGELXO 12.5 MG/1.25 GRAM PUMP	23141
VOGELXO 50 MG/5 GRAM GEL	97089
VOGELXO 50MG/5 GRAM GEL PACKET	47852



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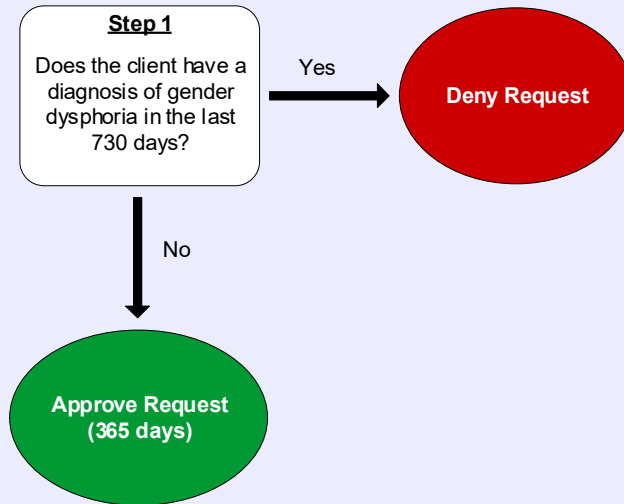
Clinical Criteria Logic

1. Does the client have a diagnosis of **gender dysphoria** in the last 730 days?
 Yes (Deny)
 No (Approve – 365 days)



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Clinical Criteria Logic Diagram





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Clinical Criteria Supporting Tables

Step 2 (diagnosis of gender dysphoria) Required diagnosis: 1 Look back timeframe: 730 days	
ICD-10 Code	Description
F64.0	GENDER DYSPHORIA OF ADOLESCENCE OR ADULTHOOD
F64.1	DUAL ROLE TRASVESTISM
F64.2	GENDER IDENTITY DISORDER OF CHILDHOOD
F64.8	OTHER GENDER IDENTITY DISORDERS
F64.9	GENDER IDENTITY DISORDER, UNSPECIFIED



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Clinical Criteria References

1. 2023 ICD-10-CM Diagnosis Codes. 2023. Available at www.icd10data.com. Accessed on September 18, 2023.
2. Clinical Pharmacology [online database]. Tampa, FL: Elsevier/Gold Standard, Inc.; 2023. Available at www.clinicalpharmacology.com. Accessed on September 18, 2023.
3. Micromedex [online database]. Available at www.micromedexsolutions.com. Accessed on September 18, 2023.

Publication History

The Publication History records the publication iterations and revisions to this document. Notes for the *most current revision* are also provided in the **Revision Notes** on the first page of this document.

Publication Date	Notes
10/13/2023	<ul style="list-style-type: none">• Initial publication and presentation to the DUR Board