PEHP
Health & Benefits

PRIOR AUTHORIZATION for GENDER REASSIGNMENT SURGERY

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490. ****Please be aware that not all employer groups have a gender reassignment surgical benefit and that surgical treatment for gender dysphoria differs depending upon the birth gender of the individual.***

Section I: PATIENT INFORMATION

Date Requested:	**Name (Last, First MI):**	**DOB:**	**Age:**	**PEHP ID #:**

Section II: PROVIDER INFORMATION

***Rendering* Provider:**	***Rendering* Provider Address:**

Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** **( )**	**Facsimile:** **( )**	**Email Address:**

***Facility/Hospital*:**	***Facility/Hospital* Address:**

Facility NPI #:	**Facility TIN #:**	**Contact Person:**	**Phone:** **( )**	**Facsimile:** **( )**	**Email Address:**

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**Requested Date of Service:** **From:** **To:**	**Place of Service:** *Please check.* ☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

A. Requested Female-To-Male (FTM) Surgical Procedures: ***Please check all that apply.***

1. ☐ Hysterectomy
2. ☐ Mastectomy
3. ☐ Metoidioplasty (enlarges clitoris – in place of phalloplasty)
4. ☐ Nipple/areola reconstruction
5. ☐ Penile prostheses implantation (artificial penile prosthesis)
6. ☐ Phallic reconstruction/Phalloplasty (creation of penis)
7. ☐ Salpingo-oophorectomy (removal of ovaries)
8. ☐ Scrotoplasty (creation of scrotum)
9. ☐ Testicular prostheses implantation
10. ☐ Urethroplasty
11. ☐ Vaginectomy
12. ☐ Vulvectomy

B. Requested Male-To-Female Surgical Procedures: ***Please check all that apply.***

1. ☐ Clitoroplasty (construction of clitoris)
2. ☐ Labiaplasty (construction of labia)
3. ☐ Orchiectomy (removal of testicles)
4. ☐ Penectomy (removal of penis)
5. ☐ Vaginoplasty (construction of vagina)
6. ☐ Breast implantation/augmentation after a minimum of 12-24 months hormonal therapy

C. Are any of the following surgical procedures being requested? ***Please check all that apply.***

1. ☐ Abdominoplasty
2. ☐ Blepharoplasty
3. ☐ Brow augmentation/Lift/Reduction
4. ☐ Buttock Augmentation/Lift
5. ☐ Calf Implants/Lipofilling
6. ☐ Cheek/Malar Implants/Lipofilling
7. ☐ Chin Reshaping
8. ☐ Chondrolaryngoplasty (Adam's Apple Reduction/Thyroid Cartilage Reduction/Tracheal Shave)
9. ☐ Collagen Injections
10. ☐ Electrolysis
11. ☐ Facial Bone Reconstruction
12. ☐ Face Lift/Mid-Face Lift
13. ☐ Forehead Lift
14. ☐ Gluteal Implants/Lipofilling
15. ☐ Hair Line Advancement
16. ☐ Hair Removal (e.g., Electrolysis, Laser Hair Removal)
17. ☐ Hair Transplantation
18. ☐ Hip Implants/Lipofilling
19. ☐ Liposuction/Lipofilling
20. ☐ Lip Augmentation/Reduction/Upper Lip Shortening
21. ☐ Lower Jaw Augmentation/Reduction
22. ☐ Mastopexy
23. ☐ Neck tightening
24. ☐ Nose Implants
25. ☐ Pectoral implants/Lipofilling
26. ☐ Reduction thyroid chondroplasty
27. ☐ Rhinoplasty
28. ☐ Skin Resurfacing
29. ☐ Vocal Cord/Voice Modification Surgery
30. ☐ Other ______________________________

QUESTION	YES	NO	COMMENTS/NOTES
1. Is the patient at least 18 years old?	☐	☐	
2. Is there at least 2 signed letters *(only one [1] signed letter is required for breast removal/mastectomy in female-to-male patients)* from qualified mental health providers confirming a diagnosis of gender dysphoria as defined by Diagnostic and Statistical Manual of Mental Disorders, or DSM-5, criteria?	☐	☐	***Please attach letter(s) to request.***
3. Is there documentation that the patient has the mental capacity to make fully informed decisions, including consent to gender-affirming surgical procedures?	☐	☐	
4. Does the patient understand the required length of hospitalizations, possible complications, and post-surgical rehabilitation requirements of various surgical procedures?	☐	☐	
5. Are any other reported mental health conditions adequately controlled?	☐	☐	
6. Has the patient completed at least 12-months of successful continuous full-time real-life experience as their desired gender without returning to their original gender assigned at birth in addition to any of the following?	☐	☐	
6.a. If, Yes, did the patient function as a student in an academic setting, function in a community-based volunteer activity, and/or maintained a part or full-time employment during the real-life experience in their desired gender?	☐	☐	

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QUESTION (*cont'd*)	**YES**	**NO**	**COMMENTS/NOTES**
6.b. If, Yes, did the patient regularly participate in psychotherapy if the treating medical or behavioral health practitioner recommended it during their real-life experience in their desired gender?	☐	☐	
7. Did the patient complete at least 12 months of continuous hormonal therapy *(hormonal therapy is not required prior to mastectomy in Female-to-Male members)*, unless there is a documented contraindication to hormonal therapy?	☐	☐	
8. Has the patient obtained a legal gender marker change?	☐	☐	
9. Has the patient demonstrated progress in consolidating their gender identity, including progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health?	☐	☐	
10. Is their documentation by a therapist other than the treating therapist that the patient functions in their desired gender role?	☐	☐	
11. Have at least 2 mental health professionals diagnosed the patient with gender dysphoria and have recommended surgical treatment?	☐	☐	
12. Does the patient have a letter* from the patient's physician or mental health provider, who has treated the patient a minimum of 18 months that documents the patient's general identifying characteristics? **** At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) and capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above.***	☐	☐	***Please attach letter to request.***
13. Does the patient have a letter* from a second physician or mental health provider who is familiar with the patient's treatment and the psychological aspects of Gender Dysphoria, corroborating the information provided in the first letter? **** At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) and capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above.***	☐	☐	***Please attach letter to request.***
14. If one of the signatures on the letters indicated in question #12. and #13. is not the treating surgeon, is there a letter from the surgeon confirming that they have personally communicated with the treating therapist and or physician, as well as the patient, and have confirmed that the patient meets criteria, understands the ramifications and possible complications of surgery, and that the surgeon feels that the patient is likely to benefit from surgery?	☐	☐	

Service (s) Requested: ***Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.***

Service Description: ______________________________ CPT/HCPCS: ____________________ ☐ Bilateral ☐ Left ☐ Right

Service Description: ______________________________ CPT/HCPCS: ____________________ ☐ Bilateral ☐ Left ☐ Right

Service Description: ______________________________ CPT/HCPCS: ____________________ ☐ Bilateral ☐ Left ☐ Right

Service Description: ______________________________ CPT/HCPCS: ____________________ ☐ Bilateral ☐ Left ☐ Right

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Service Description: ______________________________ CPT/HCPCS: ____________________ ☐ Bilateral ☐ Left ☐ Right

Service Description: ______________________________ CPT/HCPCS: ____________________ ☐ Bilateral ☐ Left ☐ Right

Service Description: ______________________________ CPT/HCPCS: ____________________ ☐ Bilateral ☐ Left ☐ Right

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

****Please fax completed form, medical records, and letters to 801-366-7449.***