

USFHP Prior Authorization Request Form for  
**Estradiol (Vials/tablets/transdermal patches/gel)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

**QUESTIONS? Call 1-877-880-7007**

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

**Prior authorization does not expire. Clinical documentation may be required.**

**Step 1 Please complete patient and physician information (please print):**

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

**Step 2 Please complete the clinical assessment:**

<b>2</b>	1. What is the patient's sex?	<input type="checkbox"/> Male – Proceed to question 2 <input type="checkbox"/> Female – <b>Prior authorization is not required</b>
	2. How old is the patient?	<input type="checkbox"/> 18 years of age or younger – Proceed to question 3 <input type="checkbox"/> 19 years of age or older – Proceed to question 4
	3. What is the indication or diagnosis?	<input type="checkbox"/> Treatment of male to female hormone therapy in a natal male patient – <b>STOP - Coverage not approved</b> <input type="checkbox"/> Other diagnosis - <b>Sign and date below</b>
	4. What is the indication or diagnosis?	<input type="checkbox"/> Initiation of male to female hormone therapy in a natal male patient – Proceed to question 5 <input type="checkbox"/> Continuation of male to female hormone therapy in a natal male patient – <b>Sign and date below</b> <input type="checkbox"/> Other diagnosis - <b>Sign and date below</b>
	5. Is the patient a male active duty servicemember?	<input type="checkbox"/> Yes (Male active duty servicemembers) – <b>STOP - Coverage not approved</b> <input type="checkbox"/> No (Male non-active duty servicemembers) - <b>Sign and date below</b>

**Step 3 I certify the above is true to the best of my knowledge. Please sign and date:**

<b>3</b>	_____	_____
	Prescriber Signature	Date