AmeriHealth Caritas™
New Hampshire

To: AmeriHealth Caritas New Hampshire Medicaid Providers

Date: October 23, 2026

Subject: Treatments for Gender Dysphoria

Summary: Effective immediately per the Division of Medicaid Services, there has been an update to the drug list and services pertaining to treatment of gender dysphoria, for minors under eighteen (18) years of age, that now require prior authorization.

Puberty blocking medications used for the treatment of gender dysphoria in minors as disallowed by the practice of medicine in New Hampshire under state law shall not be covered, unless the clinical need for the minor is consistent with exemptions in state law as defined in RSA 332-M:2, II.

Hormone medications used for the treatment of gender dysphoria in minors as disallowed by the practice of medicine in New Hampshire under state law shall not be covered, unless the clinical need for the minor is consistent with exemptions in state law as defined in RSA 332-M:2, II or was initiated prior to January 1, 2026.

Surgical procedures used for the treatment of gender dysphoria in minors as disallowed by the practice of medicine in New Hampshire under state law shall not be covered, unless the clinical need for the minor is consistent with exemptions in state law as defined in RSA 332-M:2, II.

Prior authorization is now required for puberty blocking medications, hormone medications, surgical procedures used for the treatment of gender dysphoria for minors under eighteen (18) years of age.

Puberty blocking, hormone medications, and surgery used for the treatment of gender dysphoria in minors will not be covered unless the clinical need for the minor is consistent with exemptions in state law.

As a reminder, when you do need to verify whether a service requires prior authorization, use the Prior Authorization Lookup Tool on the provider website at:

https://www.amerihealthcaritasnh.com/provider/resources/prior-auth/prior-authorization-lookup

https://www.amerihealthcaritasnh.com/content/dam/amerihealth-caritas/acnh/pdf/provider/prior-authorization-criteria.pdf.coredownload.inline.pdf

Appendix A (Drug List)

HIC3	HIC3 Desc	Generic Drug Name	Route
F1A	ANDROGENIC AGENTS	METHYLTESTOSTERONE	ORAL
F1A	ANDROGENIC AGENTS	TESTOSTERONE	IMPLANT
F1A	ANDROGENIC AGENTS	TESTOSTERONE	NASAL
F1A	ANDROGENIC AGENTS	TESTOSTERONE	TRANSDERM
F1A	ANDROGENIC AGENTS	TESTOSTERONE CYPIONATE	INTRAMUSC
F1A	ANDROGENIC AGENTS	TESTOSTERONE ENANTHATE	SUBCUT
F1A	ANDROGENIC AGENTS	TESTOSTERONE UNDECANOATE	INTRAMUSC
F1A	ANDROGENIC AGENTS	TESTOSTERONE UNDECANOATE	ORAL
G1A	ESTROGENIC AGENTS	ESTRADIOL	ORAL
G1A	ESTROGENIC AGENTS	ESTRADIOL	TRANSDERM
G1A	ESTROGENIC AGENTS	ESTRADIOL CYPIONATE	INTRAMUSC
G1A	ESTROGENIC AGENTS	ESTRADIOL VALERATE	INTRAMUSC
G1A	ESTROGENIC AGENTS	ESTRADIOL/LEVONORGESTREL	TRANSDERM
G1A	ESTROGENIC AGENTS	ESTRADIOL/NORETHINDRONE ACET	ORAL
G1A	ESTROGENIC AGENTS	ESTRADIOL/NORETHINDRONE ACET	TRANSDERM
G1A	ESTROGENIC AGENTS	ESTROGEN,CON/M-PROGEST ACET	ORAL

G1A	ESTROGENIC AGENTS	ESTROGENS, CONJUGATED	INJECTION
G1A	ESTROGENIC AGENTS	ESTROGENS, CONJUGATED	ORAL
G1A	ESTROGENIC AGENTS	NORETHINDRONE AC/ETH ESTRADIOL	ORAL
G1D	ESTROGEN-PROGESTIN WITH ANTIMINERALOCORTICOID COMB	DROSPIRENONE/ESTRADIOL	ORAL
G1F	ESTROGEN AND PROGESTIN COMBINATIONS	ESTRADIOL/PROGESTERONE	ORAL
G1G	ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD(SERM)COMB	ESTROGENS,CONJ/BAZEDOXIFENE	ORAL
G2A	PROGESTATIONAL AGENTS	MEDROXYPROGESTERONE ACETATE	ORAL
G2A	PROGESTATIONAL AGENTS	NORETHINDRONE ACETATE	ORAL
G2A	PROGESTATIONAL AGENTS	PROGESTERONE	INTRAMUSC
G2A	PROGESTATIONAL AGENTS	PROGESTERONE, MICRONIZED	ORAL
G2A	PROGESTATIONAL AGENTS	PROGESTERONE, MICRONIZED	VAGINAL
P1M	LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS	LEUPROLIDE ACETATE	INTRAMUSC
P1M	LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS	NAFARELIN ACETATE	NASAL

P1P	LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	HISTRELIN ACETATE	IMPLANT
P1P	LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	LEUPROLIDE ACETATE	INTRAMUSC
P1P	LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	LEUPROLIDE ACETATE	SUBCUT
P1P	LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	TRIPTORELIN PAMOATE	INTRAMUSC
Q4D	VAGINAL ESTROGEN FOR SEXUAL DYSFUNCTION	ESTRADIOL	VAGINAL
Q4K	VAGINAL ESTROGEN PREPARATIONS	ESTRADIOL ACETATE	VAGINAL
Q4K	VAGINAL ESTROGEN PREPARATIONS	ESTROGENS, CONJUGATED	VAGINAL

Appendix B **List of Surgical Procedures Requiring Prior Authorization and Policy Implementation**

Penectomy

Urethroplasty

Mammoplasty

Mastectomy

Clitoroplasty

Vulvoplasty

Labiaplasty

Vaginectomy

Vulvectomy

Scrotoplasty

Testicular prosthesis

Blepharoplasty

Face lift/mid-face lift/brow lift;

Facial implants and bone reconstruction;

Hair removal/electrolysis;

Hair transplantation or hairline advancement;

Prosthetic or filler substances to alter contour;

Rhinoplasty;

Thyroid chondroplasty;

Removal of redundant skin;

Upper lip shortening and lip augmentation;

Chondrolaryngoplasty;

Voice modification surgery

Questions: If you have questions about this communication or would like a full list of codes affected by this change, please contact your Provider Account Executive or the Provider Services department at **1-888-599-1479.**