Gender Confirming Surgery (GCS) is insured under PEI Medicare when prior authorization has been obtained from Health PEI.

Instructions

A. This GCS application form must be completed to request prior approval for payment by Medicare.

B. If completed manually, print clearly and ensure that all sections of this form are submitted.

C. A PEI Physician or Nurse Practitioner must request out of province approval through the Medicare Claims system.

D. The referring Physician or Nurse Practitioner submitting a request for prior authorization may be the provider completing a referral letter. They do not have to be a GCS trained physician or nurse practitioner, however they must have consulted a GCS trained Physician or Mental Health Professional that meet version 8 or the latest version of the World Professional Association for Transgender Health (WPATH) Standard of Care (as described in Appendix B).

E. The assessments accompanying this application form must be completed by a Physician or Mental Health Professional that meet version 8 or the latest version of the World Professional Association for Transgender Health (WPATH) Standard of Care. Each GCS trained Physician or Mental Health Professional must fill out the declaration in Appendix D.

F. Referral letter(s) recommending surgery must be completed by an appropriately trained Physician or Mental Health Professional who meets the WPATH minimum credentials (as described in Appendix B).

G. Referring providers will be notified regarding the funding outcome of this application, and in cases of approval, are expected to forward referral information to the provider who will be preforming the procedure. Health PEI will also advise the provider of any funding approvals for GCS when the patient identifies the provider they have selected.

H. For procedures only provided outside of Prince Edward Island Completed applications forms and attachments can be sent by mail or fax to:

Out-of-Province Coordinators
Health PEI

16 Garfield Street, Charlottetown, PE C1A 7N8

Telephone: (902) 368-6516
Fax: (902) 569-0581

Telephone: (902) 916-0672
Fax: (902) 370-3029

Version: Aug 29-2023

1. Patient Information

Last name: _____

First name: _____ Middle name: _____

Address: _____

_____ Postal code: _____

Phone number: (____) _____ Date of birth (yyyy/mm/dd): _____

Medicare Health Card #: _____ Expiry Date (yyyy/mm/dd): _____

2 Complete Patient Declaration

I am a permanent resident of Prince Edward Island.	☐ Yes ☐ No
I am 18 years old.	☐ Yes ☐ No
I am registered with PEI Medicare and possess a valid PEI Health Card.	☐ Yes ☐ No
My physician /nurse practitioner/mental health professional has explained the risks and complications associated with GCS	☐ Yes ☐ No
I understand that chest surgery and genital reconstruction (Appendix C) for the purpose of GCS are only publicly funded if pre-approved by the Out of Province Coordinator of Health PEI. However, an orchidectomy, for the purposes of GCS, is also publicly funded if performed in a publicly funded hospital in Canada, preferably in PEI.	☐ Yes ☐ No
I understand that there is no public funding available for: • GCS services outside of Canada. • Any take-home medications, equipment, meals, travel, accommodation and other personal expenses.	☐ Yes ☐ No
I have read and understand Health PEI's Out-of-Province Travel Support Program Policy and understand that I may apply for assistance as applicable.	☐ Yes ☐ No

3 Sign the certification and consent—Patient

I certify that the information given on this form is complete and accurate.

I understand that my personal health information collected on this form and the attached supporting documents will only be used to process my request and will not be disclosed without my consent unless required by law.

Name (please print): _____

Signature: _____ Date: _____

4 Referring Physician or Nurse Practitioner

Last name: _____

First name: _____ Provider ID # : _____

Office Address: _____

Phone number: ( ) _____ Fax number: ( ) _____

5 Proposed procedure(s) for which prior approval is requested:

Please check the procedure(s) for which prior approval is being requested (please refer to the complete list in Appendix C):

Chest Surgery:	
☐	Masculinization of the torso or Mastectomy (excluding implants)
☐	Feminization of the torso (including breast augmentation)
Genital Surgery:	
☐	Orchidectomy
☐	Hysterectomy/bilateral salpingo- oophorectomy
Genital Reconstruction:	
☐	Vaginoplasty with vaginal cavity
☐	Vaginoplasty without vaginal cavity
☐	Metoidioplasty
☐	Phalloplasty (Phase I)
☐	Phalloplasty (Phase II: Construction of the urethra)
☐	Insertion of testicular implants
☐	Insertion of penile implant
Facial Feminization Surgery:	
☐	Facial Feminization Surgery
Other Surgeries:	
☐	Vocal Surgery

6 Complete Physician/Nurse Practitioner Declaration

I have verified that the patient meets all of the general criteria for GCS:

- The patient is a permanent resident of PEI. ☐ Yes ☐ No
- The patient is registered with PEI Medicare and possesses a valid PEI Health Card. ☐ Yes ☐ No
- I am a "qualified health professional" as described by the WPATH Standard of Care. ☐ Yes ☐ No
- I am acting as the referring physician/NP for this patient and I have consulted qualified health professionals as described by the WPATH Standard of Care for assessments and referral letter for this patient. ☐ Yes ☐ No

PRIMARY CLINICAL CRITERIA:

I have verified that the patient has:

o Persistent, well-documented gender incongruence ☐ Yes ☐No

- o Understands the procedure/s ☐ Yes ☐ No
- o Understands associated risk/s and complications ☐ Yes ☐ No
- o Has an aftercare / follow-up plan ☐ Yes ☐ No
- o Reasonably well controlled medical or mental health concerns, if they are present ☐ Yes ☐ No

SPECIFIC CLINICAL CRITERIA:

Genital Surgery:
Orchidectomy

- The patient has **a** referral letter signed by a GCS trained and qualified physician or nurse practitioner (Appendix B). ☐ Yes ☐ No
- The patient is stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated). [Recommended, not required.] ☐ Yes ☐ No
- The patient has reached 18 years of age. ☐ Yes ☐ No

Genital Reconstruction:
Vaginoplasty (with or without vaginal cavity), Metoidioplasty, Phalloplasty (Phase II and II), Insertion of testicular implants, Insertion of penile implant

- The referral letter must be from a GCS trained and qualified physician or nurse practitioner. ☐ Yes ☐ No
- The patient is stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated). [Recommended, not required.] ☐ Yes ☐ No
- The patient has reached 18 years of age. ☐ Yes ☐ No

ADDITIONAL CLINICAL CRITERIA:

- The patient is physically fit and has no significant physical health problems that would contraindicate or complicate the proposed surgery ☐ Yes ☐ No
- The patient is psychologically prepared for surgery. ☐ Yes ☐ No
- The patient is informed of and understands any alternative procedures. ☐ Yes ☐ No
- The patient has engaged in a responsible way with the assessment/treatment process. ☐ Yes ☐ No
- The patient has an adequate support network, a stable lifestyle and the gender identity of the individual has remained stable over time. ☐ Yes ☐ No

7. Inform patient of Out of Province Travel Support Programs

I have reviewed the Health PEI Out of Province Travel Support Programs with the patient. ☐ Yes ☐ No

8 Attach supporting documents:

Required attachment(s):	Attached:
• One supporting referral letter signed by a GCS trained and qualified physician or nurse practitioner	☐ Yes ☐ No
• Proof of training from the consulting physician / NP or signed declaration (Appendix D) that confirms that the referent has training in the area of GCS or gender incongruence (may be included in the referral letter itself).	☐ Yes ☐ No
• Report from physician /NP who has been prescribing and supervising the hormone replacement therapy (HRT) as applicable.	☐ Yes ☐ No
• Operative reports of the patient's prior GCS and/or treatment (For phalloplasty and metoidioplasty an operative and pathology report showing a hysterectomy and that the entire cervix has been removed is required) as applicable	☐ Yes ☐ No

9 Certification and recommendation signature

- I certify that the information given on this form is complete and accurate
- I recommend this client for gender confirming surgery

Name (please print):_____

Signature:_____ Date: _____

For Health PEI Staff Use Only:

*Authorized Signature:*_____*: Date:*_____

APPENDIX A: SUMMARY CRITERIA FOR HORMONAL AND SURGICAL TREATMENTS FOR ADULTS AND ADOLESCENTS (WPATH SOC 8) (Source: https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644)

Appendix D SUMMARY CRITERIA FOR HORMONAL AND SURGICAL TREATMENTS FOR ADULTS AND ADOLESCENTS

The SOC-8 guidelines are intended to be flexible in order to meet the diverse health care needs of TGD people globally. While adaptable, they offer consensus-based standards derived from the best available scientific evidence for promoting optimal health care and guiding the treatment of people experiencing gender incongruence. As in all previous versions of the SOC, the criteria put forth in this document for gender affirming interventions are clinical guidelines; individual health care professionals and programs, in consultation with the TGD person, may modify them. Clinical departures from the SOC may occur due to a TGD person's unique anatomic, social, or psychological situation; an experienced health care professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies. These departures should be recognized as such, discussed with the TGD person, and documented. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care—and the SOC—to evolve. This summary criteria needs to be read in conjunction with the relevant chapters (see Adult Assessment and Adolescent chapters).

SUMMARY CRITERIA FOR ADULTS

Related to the assessment process

- Health care professionals assessing transgender and gender diverse adults seeking gender-affirming treatment should liaise with professionals from different disciplines within the field of trans health for consultation and referral, if required*
- If written documentation or a letter is required to recommend gender affirming medical and surgical treatment (GAMST), only one letter of assessment from a health care professional who has competencies in the assessment of transgender and gender diverse people is needed.

Criteria for hormones

a. Gender incongruence is marked and sustained;
b. Meets diagnostic criteria for gender incongruence prior to gender-affirming hormone treatment in regions where a diagnosis is necessary to access health care;
c. Demonstrates capacity to consent for the specific gender-affirming hormone treatment;
d. Other possible causes of apparent gender incongruence have been identified and excluded;
e. Mental health and physical conditions that could negatively impact the outcome of treatment have been assessed, with risks and benefits discussed;
f. Understands the effect of gender-affirming hormone treatment on reproduction and they have explored reproductive options.

Criteria for surgery

a. Gender incongruence is marked and sustained;
b. Meets diagnostic criteria for gender incongruence prior to gender-affirming surgical intervention in regions where a diagnosis is necessary to access health care;
c. Demonstrates capacity to consent for the specific gender-affirming surgical intervention;
d. Understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options;
e. Other possible causes of apparent gender incongruence have been identified and excluded;
f. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits have been discussed;
g. Stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).*

*These were graded as suggested criteria

APPENDIX B: Minimum credentials of providers who are qualified to complete the GCS Prior Approval Request Form and/or a referral letter.

Statements of Recommendations 5.1- Source WPATH SOC 8
(https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644)

We recommend health care professionals assessing transgender and gender diverse adults for physical treatments:
5.1.a- Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.

5.1.b- For countries requiring a diagnosis for access to care, the health care professional should be competent using the latest edition of the World Health Organization's International Classification of Diseases (ICD) for diagnosis. In countries that have not implemented the latest ICD, other taxonomies may be used; efforts should be undertaken to utilize the latest ICD as soon as practicable.

5.1.c- Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.

5.1.d- Are able to assess capacity to consent for treatment.

5.1.e- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.

5.1.f- Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.

5.2- We suggest health care professionals assessing transgender and gender diverse adults seeking gender-affirming treatment liaise with professionals from different disciplines within the field of transgender health for consultation and referral, if required. The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (all should be met):

5.3- We recommend health care professionals assessing transgender and gender diverse adults for gender-affirming medical and surgical treatment:

5.3.a- Only recommend gender-affirming medical treatment requested by a TGD person when the experience of gender incongruence is marked and sustained.

5.3.b- Ensure fulfillment of diagnostic criteria prior to initiating gender-affirming treatments in regions where a diagnosis is necessary to access health care.

5.3.c- Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments.

5.3.d- Ensure that any mental health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.

5.3.e- Ensure any physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.

5.3.f- Assess the capacity to consent for the specific physical treatment prior to the initiation of this treatment.

5.3.g- Assess the capacity of the gender diverse and transgender adult to understand the effect of gender-affirming treatment on reproduction and explore reproductive options with the individual prior to the initiation of gender-affirming treatment.

5.4- We suggest, as part of the assessment for gender-affirming hormonal or surgical treatment, professionals who have competencies in the assessment of transgender and gender diverse people wishing gender-related medical treatment consider the role of social transition together with the individual.

5.5- We recommend transgender and gender diverse adults who fulfill the criteria for gender-affirming medical and surgical treatment require a single opinion for the initiation of this treatment from a professional who has competencies in the assessment of transgender and gender diverse people wishing gender-related medical and surgical treatment.

5.6- We suggest health care professionals assessing transgender and gender diverse people seeking gonadectomy consider a minimum of 6 months of hormone therapy as appropriate to the TGD person's gender goals before the TGD person undergoes irreversible surgical intervention (unless hormones are not clinically indicated for the individual).

5.7- We recommend health care professionals assessing adults who wish to de-transition and seek gender-related hormone intervention, surgical intervention, or both, utilize a comprehensive multidisciplinary assessment that will include additional viewpoints from experienced health care professional in transgender health and that considers, together with the individual, the role of social transition as part of the assessment process.

APPENDIX C: List of Procedures in Gender Confirming Surgery

(a) Chest Surgery:

- Masculinization of the chest or Mastectomy as clinically indicated
- Feminization of the chest or Breast Augmentation as clinically indicated

(b) Genital Surgery:

- Orchidectomy (can be performed as a solo procedure if no vaginoplasty is intended in the future).
- Hysterectomy with bilateral salpingo- oophorectomy

(c) Genital Reconstruction:

- Vaginoplasty with vaginal cavity
- Vaginoplasty without vaginal cavity
- Metoidioplasty
- Phalloplasty (Phase I)
- Phalloplasty (Phase II)
- Urethroplasty
- Insertion of testicular implants
- Insertion of penile implant

(d) Facial feminization surgery

(e) Vocal Surgery

From: Health PEI Gender-Affirming Procedure Approval Policy (2023)

APPENDIX D: Signed Declaration

I declare that I obtained training in the area of Gender Confirming Surgery or Gender Dysphoria. My training includes:

- ☐ Attending relevant professional
- ☐ meetings Workshops
- ☐ Seminars
- ☐ Supervision from a mental health professional with relevant experience
- ☐ Participating in research related to gender non-conformity and gender dysphoria
- ☐ Other: _____

Name (please print): _____

Signature:_____Date: _____