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 also be one of the providers 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 7 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 7 or the latest version of the World Professional Association for Transgender Health (WPATH) Standard of Care (as described in Appendix B). 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 Centre Métropolitain de Chirurgie in Montreal. Health PEI will advise the Centre Métropolitain de Chirurgie in Montreal of any funding approvals for GCS surgery.

H. Completed applications forms and attachments can be sent by mail or fax to:

Out-of-Province Coordinator
Health PEI

16 Garfield Street
Charlottetown, PE C1A 7N8

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

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 registered with PEI Medicare and possess a valid PEI Health Card. ☐ Yes ☐ No

I am 18 years old. ☐ Yes ☐ No

My physician /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 publically funded if performed at the Centre Métropolitain de Chirurgie Montréal, Québec and pre-approved by the Out of Province Coordinator of Health PEI. However, an orchidectomy, for the purposes of GCS, is also publically funded if performed in a Publically funded hospital in Canada, preferably in PEI. ☐ Yes ☐ No

I understand that there is no public funding available for:

- GCS services outside of Canada. ☐ Yes ☐ No
- GCS services received without prior approval from the Out of Province Coordinator at Health PEI. ☐ Yes ☐ No
- Any services which are not insured by PEI Medicare, including but not limited to: facial feminization, liposuction, tracheal shave, voice pitch surgery, breast augmentation and hair removal. ☐ Yes ☐ No
- 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 Mental Health Professional

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)
Genital Surgery:	
☐	Orchidectomy
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

6 Complete Physician 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 letters for this patient. ☐ Yes ☐ No

PRIMARY CLINICAL CRITERIA

I have verified that the patient has:

- Persistent, well-documented gender dysphoria diagnosis ☐ Yes ☐ No
- Capacity to make a fully informed decision and to consent for treatment: ☐ Yes ☐ No
  - Understands the procedure/s
  - Understands associated risk/s and complications
  - Has an aftercare / follow-up plan
- Reasonably well controlled medical or mental health concerns, if they are present ☐ Yes ☐ No

SPECIFIC CLINICAL CRITERIA:

Chest Surgery:
Masculinization of the torso or Mastectomy (excluding implants)

- The patient has **one** supporting referral letter signed by a GCS trained physician or qualified mental health professional ☐ Yes ☐ No
- The patient has reached 18 years of age. ☐ Yes ☐ No

Genital Surgery:
Orchidectomy

- The patient has **two** referral letters signed by a GCS trained and qualified mental health professional (Appendix B). If the first referral letter (Supporting referral letter) is from a Physician or a Mental Health Professional who mainly had a clinical relationship with the patient, the second referral letter (Assessment referral letter) must be from a different physician or Mental Health Professional who had an evaluative role with the patient. ☐ Yes ☐ No
- 12 continuous months of hormone therapy as appropriate to the patient`s gender roles (unless there is medical contraindication, or inability / unwillingness to undergo hormone therapy). ☐ 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 patient has **two** referral letters signed by a GCS trained and qualified mental health professional (Appendix B). If the first referral letter (Supporting referral letter) is from a Physician or a Mental Health Professional who mainly had a clinical relationship with the patient, the second referral letter (Assessment referral letter) must be from a different physician or Mental Health Professional who had an evaluative role with the patient. ☐ Yes ☐ No
- 12 continuous months of hormone therapy as appropriate to the patient`s gender roles (unless there is medical contraindication, or inability / unwillingness to undergo hormone therapy). ☐ Yes ☐ No
- 12 continuous months of living in a gender role that is congruent with their gender identity (unless a specific reason has been stated in a referral letter). ☐ 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 has realistic goals and expectations of the 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 or two supporting referral letters (depending on surgery) signed by a GCS trained and qualified Physician or Mental Health Professional. **NOTE**: *If the first referral letter (Supporting referral letter) is from a Physician or a Mental Health Professional who mainly had a clinical relationship with the patient, the second referral letter (Assessment referral letter) must be from a different physician or Mental Health Professional who had an evaluative role with the patient.*	☐ Yes ☐ No
• Proof of training from the consulting physician / Mental Health Professionals or signed declaration (Appendix D) that confirms that the referent has training in the area of GCS or gender dysphoria (may be included in the referral letter itself)	☐ Yes ☐ No
• Report from physician 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 metoidoplasty 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: Content of the referral letter(s)

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;
5. A statement about the fact that informed consent has been obtained from the patient;
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

WPATH, Standard of Care, V.7

APPENDIX B: Minimum credentials of Mental Health Professionals who are qualified to complete the GCS Prior Approval Request Form and/or referral letter(s).

The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree, or a more advanced one, should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender-nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that the mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.

Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

WPATH, Standard of Care, V.7

APPENDIX C: List of Procedures in Gender Confirming Surgery

Chest Surgery at the Centre Métropolitain de Chirurgie in Montreal:

- Masculinization of the torso or Mastectomy (excluding implants)

Genital Surgery at the Centre Métropolitain de Chirurgie in Montreal:

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

Genital Reconstruction at the Centre Métropolitain de Chirurgie in Montreal:

- Vaginoplasty (with or without construction of the vaginal cavity.)
- Metoidioplasty
- Phalloplasty (Phase I)
- Phalloplasty (Phase II - Construction of the urethra)
- Insertion of testicular implants
- Insertion of penile implant

Please note that for phalloplasty and metoidioplasty surgeries, a hysterectomy operative report (the cervix must be completely removed) and a pathology report confirming this must be provided to the Centre Métropolitain de Chirurgie in Montreal.

Depending on the requirements of each individual patient, the above-listed procedures may be performed alone or in combination with each other.

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: _____