HCAi
Department of Health Care Access and Information

Gender Affirming Care Medication for Children and Youth

PROVIDER ATTESTATION

This Provider Attestation must be included with each prescription completed by a prescribing provider to request the Department of Health Care Access and Information (HCAI) fund gender affirming care medications for eligible youth through a prescription dispensed by Pucci's Pharmacy. The Provider Attestation may only be used to request payment for clinically appropriate gender affirming care medications for youth under age 18 and currently enrolled in Medi-Cal or under age 19 and currently enrolled in Children's Health Insurance Program (CHIP) administered by the California Department of Health Care Services (DHCS).

One Provider Attestation must be completed per patient, inclusive of refills. This form cannot be used to request medications for multiple patients.

1. **Provider Information**

Provider Full Name: _____

Address: _____

_____

Phone Number: _____

CA License No. _____

2. **Patient Information**

Patient Full Name: _____
(As Stated on Prescription)

3. **Medication Information**

Medication Name(s) _____

(include medication name, not dosage or directions): _____

_____

4. **Additional Attestations**

I, the provider named above, attest that all the following statements are true and correct:

a. The prescribed medication is medically necessary for the patient.

b. The prescribed medication and course of treatment meet the World Professional Association for Transgender Health's (WPATH) "Standards of Care for the Health of Transgender and Gender Diverse People," Version 8 (2022), or subsequent version, for the patient.

c. To the best of my knowledge, the patient is either:
   i. Under age 18 and currently enrolled in Medi-Cal; or
   ii. Under age 19 and currently enrolled in Children's Health Insurance Program (CHIP) administered by the California Department of Health Care Services.

d. To the best of my knowledge, the patient does not have health care coverage for the prescribed medication from any other health care payer or any other health care service plan or health insurer. Patients who may have access to Medicaid/Medi-Cal or CHIP health coverage under the federal "tapering period" for hormone therapy are not included in the scope of this statement.

e. If I become aware of the patient having health coverage from any other health care payer during the time that the prescription is valid (including refills), I will notify Pucci's Pharmacy at clint@puccirx.com. Patients who may have access to Medicaid/Medi-Cal or CHIP health coverage under the federal "tapering period" for hormone therapy are not included in the scope of this statement.

f. For any medications shipped to me, I agree to only deliver the medication to the patient for which it was prescribed under this Provider Attestation or that patient's authorized representative. I agree that any other use, transfer, or sale of the medication by or to any other person or entity is unauthorized. I understand that in the event of an unauthorized use, transfer, or sale of the medication, the State may exercise all rights and remedies available at law or in equity to recover the medications, costs associated with the medications, and any associated damages, losses, or expenses incurred by the State.

g. I attest that I have not engaged and will not engage in fraudulent or misleading billing practices related to the prescribed medication.

h. I agree that if the patient or their authorized representative declines to accept or returns the prescribed medication, I will notify Pucci's Pharmacy at clint@puccirx.com.

This attestation is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The provider signing this attestation warrants that they have read this attestation and understand it.

I, the undersigned, declares under penalty of perjury under the laws of the State of California that the information in this Provider Attestation is true, accurate, and complete to the best of my knowledge and belief.

Provider's Signature: _____

Printed Name of Provider Signing Attestation: _____

Provider's Title: _____

Date of Signature: _____