USFHP Prior Authorization Request Form for leuprolide SC injection **(Camcevi Kit)**

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):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date of Birth:		Secure Fax #:	

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

1. How old is the patient?	☐ 18 years of age or younger - Proceed to question **2** ☐ 19 years of age or older - Proceed to question **3**	
2. What is the diagnosis or indication?	☐ Gender dysphoria – **STOP - Coverage not approved** ☐ Other indication - Proceed to question **3**	
3. The provider is aware that leuprolide acetate SQ (Eligard) is the preferred leuprolide product for TRICARE and does not require prior authorization for adults.	☐ Acknowledged Proceed to question **4**	
4. Has the patient tried and failed or has not been able to tolerate Eligard?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

Prescriber Signature _____ Date _____

[26 May 2025]