

**USFHP Prior Authorization Request Form for
elinzanetant (Lynkuet)**

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 expires in 6 months. Initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely.

Step 1 Please complete patient and physician information (please print):

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

Step 2 Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.</i>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 8	<input type="checkbox"/> No Proceed to question 2
2. Does the patient have moderate to severe vasomotor symptoms due to menopause?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have a contraindication to menopausal hormone therapy (estrogens with or without progestins)?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 4
4. Does the patient have an intolerance to menopausal hormone therapy?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 5
5. Has the provider determined that the patient is not a candidate for menopausal hormone therapy, based on individual patient characteristics and risk factors?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Has the patient tried and failed AT LEAST ONE of the following non-hormonal treatments for vasomotor symptoms: an SSRI (for example, paroxetine, escitalopram, or citalopram), an SNRI (for example, venlafaxine, desvenlafaxine, or duloxetine), OR gabapentin?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 7

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7. Has the patient had an adverse reaction to AT LEAST ONE of the following non-hormonal treatments for vasomotor symptoms: an SSRI (for example, paroxetine, escitalopram, or citalopram), an SNRI (for example, venlafaxine, desvenlafaxine, or duloxetine), OR gabapentin?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
8. Has the patient had a positive response to therapy as noted by a decrease in the number of moderate to severe hot flashes?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[06 February 2026]