TRICARE Prior Authorization Request Form for
Lupron Depot IM, Lutrate Depot, leuprolide acetate IM, Vabrinty

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior Authorization does not expire.

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. What is the diagnosis or indication?	☐ Gender dysphoria - Proceed to question **2** ☐ Fertility - Proceed to question **3** ☐ Other indication - Proceed to question **4**	
2. How old is the patient?	☐ 18 years of age or younger - **STOP - Coverage not approved** ☐ 19 years of age or older - Proceed to question **4**	
3. Is the fertility agent being prescribed for use in conjunction with a noncoital reproductive technology, including but not limited to artificial insemination, in vitro fertilization, OR gamete intrafallopian transfer? Note: The TRICARE family planning benefit outlined in the Code of Federal Regulations does not include services and supplies related to noncoital reproductive technology.	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. 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 **5**	

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5. 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 August 2026]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: