TRICARE Prior Authorization Request Form for
elinzanetant (Lynkuet)

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 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):

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? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐Yes (subject to verification) Proceed to question **8**	☐No Proceed to question **2**
2. Does the patient have moderate to severe vasomotor symptoms due to menopause?	☐Yes Proceed to question **3**	☐No **STOP** **Coverage not approved**
3. Does the patient have a contraindication to menopausal hormone therapy (estrogens with or without progestins)?	☐Yes Proceed to question **6**	☐No Proceed to question **4**
4. **Does the patient have an intolerance to menopausal hormone therapy?**	☐Yes Proceed to question **6**	☐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?	☐Yes Proceed to question **6**	☐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?	☐Yes **Sign and date below**	☐No Proceed to question **7**

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?	☐Yes **Sign and date below**	☐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?	☐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

[06 February 2026]

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