REALRx

Commercial
Individual & Family

PRIOR AUTHORIZATION REQUEST FORM

VASOMOTOR AGENTS

Lynkuet®, Veozah™

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Lynkuet® (elinzanetant), ☐ Veozah™ (fezolinetant)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of menopause defined by one of the following: • Spontaneous amenorrhea for ≥ 12 consecutive months • Spontaneous amenorrhea for ≥ 6 months with follicle-stimulating hormone (FSH) > 40 IU/L • Had bilateral oophorectomy ≥ 6 weeks prior to screening visit	☐	☐	**Please provide documentation**
2. Does the member have an average of 7 or more moderate to severe hot flashes per day?	☐	☐	**Please provide documentation**
3. Has the member tried and failed each of the following at the maximum tolerated FDA-approved dose for at least 3 months: • hormone therapy (e.g. estradiol, oral conjugated estrogens, micronized progesterone) • selective serotonin reuptake inhibitor (e.g. paroxetine, citalopram) • serotonin and norepinephrine reuptake inhibitor (e.g. venlafaxine, desvenlafaxine)	☒	☐	**Please provide documentation**
4. Does documentation include baseline liver and renal function tests?	☐	☐	**Please provide documentation**

5. Does the member have contraindications per the FDA package insert?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had a positive clinical response to therapy, defined as a reduction in both frequency and severity of vasomotor symptoms (i.e. hot flashes)?	☐	☐	**Please provide documentation**
3. Has the member's liver function been monitor as recommended by the FDA-approved package insert	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
PRESCRIBER CERTIFICATION			
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.			
Physician's Signature:			**Date:**

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Policy: PHARM-193
Origination Date: 09/01/2023
Reviewed/Revised Date: 01/14/2026
Next Review Date: 01/14/2027
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