TRICARE Prior Authorization Request Form for
atogepant **(Qulipta)**

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

USFHP Pharmacy Prior Authorization Form

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

FAX Completed Form and Applicable Progress Notes to:
(410) 424-4037

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

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

Approval for initial is 6 months; for continuation therapy is indefinite.

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 Qulipta.*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **4**
2. Has the patient had a reduction in mean monthly headache days of greater than or equal to 50% relative to the pretreatment baseline (as shown by patient diary documentation or healthcare provider attestation)?	☐ Yes **Sign and date below**	☐ No Proceed to question **3**
3. Has the patient shown a clinically meaningful improvement in ANY of the following validated migraine-specific patient-reported outcome measures: ○ **Migraine Disability Assessment (MIDAS): reduction of greater than or equal to 5 points when baseline score is 11-20; reduction of greater than or equal to 30% when baseline score is greater than 20;** ○ **Headache Impact Test (HIT-6): reduction of greater than or equal to 5 points; OR** ○ **Migraine Physical Functional Impact Diary (MPFID): reduction of greater than or equal to 5 points?**	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
4. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Is the requested medication prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

6. Will the requested medication be used concurrently with any small molecule CGRP targeted medication (for example, Ubrelvy, Nurtec ODT or another gepant)?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **7**
7. Does the patient have a diagnosis of chronic migraine?	☐ Yes Proceed to question **12**	☐ No Proceed to question **8**
8. Is the requested medication being used for prevention of episodic migraine?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Does the patient have episodic migraines at a rate of 4 to 7 migraine days per month for 3 months?	☐ Yes Proceed to question **10**	☐ No Proceed to question **11**
10. Does the patient have at least moderate disability shown by Migraine Disability Assessment (MIDAS) Test score greater than 11 OR Headache Impact Test-6 (HIT-6) score greater than 50?	☐ Yes Proceed to question **12**	☐ No Proceed to question **11**
11. Does the patient have episodic migraine at a rate of 8 to 14 migraine days per month for 3 months?	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved
12. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of at least ONE drug from TWO of the following migraine prophylactic drug classes: ○ **prophylactic antiepileptic medications: valproate, divalproic acid, topiramate;** ○ **prophylactic beta-blocker medications: metoprolol, propranolol, atenolol, nadolol, timolol;** ○ **prophylactic antidepressants: amitriptyline, duloxetine, nortriptyline, venlafaxine?**	☐ Yes Proceed to question **13**	☐ No **STOP** Coverage not approved
13. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of at least ONE of the following CGRP injectable agents: erenumab-aooe (Aimovig), fremanezumab-vfrm (Ajovy), galcanezumab-gnlm (Emgality)?	☐ 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 December 2023]

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