Prior Authorization Request Form for
lasmiditan **(Reyvow)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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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.

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

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

1. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a history of hemorrhagic stroke?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Does the patient have a history of epilepsy or any other condition with increased risk of seizure?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. Is the requested medication being prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of at least TWO of the following medications: sumatriptan (Imitrex), rizatriptan (Maxalt), zolmitriptan (Zomig), or eletriptan (Relpax)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of Nurtec ODT?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Will Reyvow be used with a triptan?	☐ Yes Proceed to question **8**	☐ No Proceed to question **9**
8. Prescriber acknowledges Reyvow and the triptan should not be used within 24 hours of each other.	☐ Acknowledged Proceed to question **9**	
9. Does the patient have low heart rate?	☐ Yes Proceed to question **11**	☐ No Proceed to question **10**
10. Is the patient using a beta blocker such as but not limited to propranolol?	☐ Yes Proceed to question **11**	☐ No **Sign and date below**
11. Will caution be used in patients with low heart rate and/or those using beta blockers?	☐ 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

[21 August 2020]

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