

Prior Authorization Request Form for ubrogepant (Ubrelvy)



JOHNS HOPKINS
MEDICINE
HEALTHCARE

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.

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

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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1. Is the patient GREATER THAN or EQUAL to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Does the patient have clinically significant or unstable cardiovascular disease?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 3
3. Is the requested medication being prescribed by or in consultation with a neurologist?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. 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)?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of Nurtec ODT?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Will the requested medication be used in combination with any other small molecule CGRP targeted medication (for example, another "gepant" or Nurtec ODT)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below

Step 3 I certify the above is true to the best of my knowledge.
Please sign and date:

_____ Date _____

Prescriber Signature

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For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: