TRICARE Prior Authorization Request Form for
zavegepant (Zavzpret)

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.

Initial prior authorization expires after 6 months. For renewal of therapy, an initial Tricare prior authorization approval is required and is approved indefinitely if criteria are met.

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 Zavzpret,*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. Does the patient have a documented positive clinical response to therapy for acute migraine treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Will the patient be using the requested medication in combination with any other small molecule CGRP targeted medication (that is, Nurtec ODT or Ubrelvy)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. Does the patient have a diagnosis of acute treatment of migraine headache?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Does the patient have a contraindication to, intolerability to, or has failed a trial of BOTH • **sumatriptan (Imitrex) nasal spray AND** • **Nurtec ODT or Ubrelvy tablet?**	☐ 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 _____

[15 Nov 2023]

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