US Family Health Plan
Prior Authorization Request Form for fremanezumab-vfrm (**Ajovy**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **855-273-5735**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization for initial therapy will approve for 6 months. Prior authorization for continuation of therapy does not expire. For renewal of therapy an initial TRICARE/USFHP prior authorization approval is required.

usfamilyhealth.org/rx-pa

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 Ajovy*	☐ Yes (subject to verification) Proceed to question **14**	☐ No Proceed to question **2**
2. Is this medication being prescribed by or in consultation with a neurologist	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient pregnant or actively trying to become pregnant?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **5**
5. What is the indication or diagnosis?	☐ Chronic migraines - Proceed to question **9** ☐ Episodic migraines - Proceed to question **6** ☐ All other diagnosis or indications – **STOP** **Coverage not approved**	
6. Has the patient experienced three consecutive months of 8 migraine days per month?	☐ Yes Proceed to question **9**	☐ No Proceed to question **7**
7. Has the patient experienced three consecutive months of 4-7 migraine days per month?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. 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 **9**	☐ No **STOP** **Coverage not approved**

9. Will the patient use other calcitonin gene-related peptide (CGRP) inhibitors (such as Aimovig or Emgality) in combination with the requested medication?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Please note for the following questions, formulary migraine prophylactic drug classes include: • Prophylactic antiepileptic medications: valproate, divalproic acid, topiramate; • Prophylactic beta-blocker medications, examples include, metoprolol, propranolol, atenolol, nadolol, timolol; • Prophylactic antidepressants: amitriptyline, duloxetine, nortriptyline, venlafaxine.	Proceed to question **11**	
11. Has the patient tried at least ONE drug from TWO of the above migraine prophylactic drug classes?	☐ Yes Proceed to question **12**	☐ No Proceed to question **13**
12. Has the patient experienced intolerance or failure after an adequate 2 month trial of at least ONE drug from TWO of the above migraine prophylactic drug classes? *(An adequate trial is generally considered to be 6 to 8 weeks in duration because of the amount of time required to achieve maximal benefit with therapy.)*	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Does the patient have a contraindication to at least ONE drug from TWO of the above migraine prophylactic drug classes?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
14. 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 **15**
15. Has the patient shown a clinically meaningful improvement in ANY of the following validated migraine-specific patient-reported outcome measures: **A) Migraine Disability Assessment (MIDAS):** • **a reduction of 5 points or more when baseline score is 11-20 or** • **a reduction of 30% or more when baseline score is greater than 20;** **B) Headache Impact Test (HIT-6): a reduction of 5 points or more;** **C) Migraine Physical Functional Impact Diary (MPFID): a reduction of 5 points or more**	☐ 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 _____