

US Family Health Plan

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

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**

usfamilyhealth.org/rx-pa

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 a history of hemorrhagic stroke?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 3
3. Does the patient have a history of epilepsy or any other condition with increased risk of seizure?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 4
4. Is the requested medication being prescribed by or in consultation with a neurologist?	<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 at least TWO of the following medications: sumatriptan (Imitrex), rizatriptan (Maxalt), zolmitriptan (Zomig), or eletriptan (Relpax)?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

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