US family Health Plan

Prior Authorization Request Form for

Atogepant (Qulipta)

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**

Approval for initial is 6 months; for continuation therapy is indefinite.

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 Qulipta.*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **4**
2. 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 **3**
3. Has the patient shown a clinically meaningful improvement in ANY of the following validated migraine-specific patient-reported outcome measures: ○ **Migraine Disability Assessment (MIDAS): reduction of greater than or equal to 5 points when baseline score is 11-20; reduction of greater than or equal to 30% when baseline score is greater than 20;** ○ **Headache Impact Test (HIT-6): reduction of greater than or equal to 5 points; OR** ○ **Migraine Physical Functional Impact Diary (MPFID): reduction of greater than or equal to 5 points?**	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
4. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Is the requested medication prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

6. Will the requested medication be used concurrently with any small molecule CGRP targeted medication (for example, Ubrelvy, Nurtec ODT or another gepant)?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **7**
7. Does the patient have a diagnosis of chronic migraine?	☐ Yes Proceed to question **12**	☐ No Proceed to question **8**
8. Is the requested medication being used for prevention of episodic migraine?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Does the patient have episodic migraines at a rate of 4 to 7 migraine days per month for 3 months?	☐ Yes Proceed to question **10**	☐ No Proceed to question **11**
10. 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 **12**	☐ No Proceed to question **11**
11. Does the patient have episodic migraine at a rate of 8 to 14 migraine days per month for 3 months?	☐ Yes Proceed to question **12**	☐ No **STOP** Coverage not approved
12. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of at least ONE drug from TWO of the following migraine prophylactic drug classes: ○ **prophylactic antiepileptic medications: valproate, divalproic acid, topiramate;** ○ **prophylactic beta-blocker medications: metoprolol, propranolol, atenolol, nadolol, timolol;** ○ **prophylactic antidepressants: amitriptyline, duloxetine, nortriptyline, venlafaxine?**	☐ Yes Proceed to question **13**	☐ No **STOP** Coverage not approved
13. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of at least ONE of the following CGRP injectable agents: erenumab-aooe (Aimovig), fremanezumab-vfrm (Ajovy), galcanezumab-gnlm (Emgality)?	☐ 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