

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):

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2

2	1. Has the patient received this medication under the USFHP benefit in the last 6 months? Please choose "No" if the patient did not previously have a USFHP approved PA for Qulipta.	<input type="checkbox"/> Yes (subject to verification) Proceed to question 2	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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: <ul style="list-style-type: none"> ○ 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? 	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
	4. Is the requested medication being used for prevention of episodic migraine?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
	5. Does the patient have episodic migraines at a rate of 4 to 7 migraine days per month for 3 months?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No Proceed to question 7
	6. 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?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Proceed to question 7

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<p>7. Does the patient have episodic migraine at a rate of at least 8 migraine days per month for 3 months?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes Proceed to question 8</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>8. 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:</p> <ul style="list-style-type: none"> ○ prophylactic antiepileptic medications: valproate, divalproic acid, topiramate; ○ prophylactic beta-blocker medications: metoprolol, propranolol, atenolol, nadolol, timolol; ○ prophylactic antidepressants: amitriptyline, duloxetine, nortriptyline, venlafaxine? 	<p style="text-align: center;"><input type="checkbox"/> Yes Proceed to question 9</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>
<p>9. 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)?</p>	<p style="text-align: center;"><input type="checkbox"/> Yes Sign and date below</p>	<p style="text-align: center;"><input type="checkbox"/> No STOP Coverage not approved</p>

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

_____ Prescriber Signature

_____ Date

[27 December 2021]