USFHP Prior Authorization Request Form for ubrogepant **(Ubrelvy)**

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization does not expire. Clinical documentation may be required.

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. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the requested medication being prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. 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)?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Will the requested medication be used in combination with any other small molecule CGRP targeted medication (for example, another "gepant" or Nurtec ODT)?	☐ Yes **STOP** Coverage not approved	☐ No **Sign and date below**

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

_____ _____

Prescriber Signature Date

[30 April 2025]