US Family Health Plan
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**

Medical documentation may be required. Failure to provide could result in denial. Approval for initial is 6 months; for continuation of 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 #: ____________________

Question	Yes	No
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 Ubrelvy.*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. **Does the patient have a documented positive clinical response to therapy?**	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
3. **Is the patient GREATER THAN or EQUAL to 18 years of age?**	☐ Yes Proceed to question **4**	☐ No **Sign and date below**
4. **Is the requested medication being prescribed by or in consultation with a neurologist?**	☐ Yes Proceed to question **5**	☐ 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)?**	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. **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

[31 August 2022]