US Family Health Plan
Prior Authorization Request Form for
Zavegepant (Zavzpret)

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**

Initial prior authorization expires after 6 months. For renewal of therapy, an initial prior authorization approval is required and is approved indefinitely if criteria are met.

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 Zavzpret,*	☐ 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 for acute migraine treatment?	☐ 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 **STOP** **Coverage not approved**
4. Is the requested medication prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Will the patient be using the requested medication in combination with any other small molecule CGRP targeted medication (that is, Nurtec ODT or Ubrelvy)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. Does the patient have a diagnosis of acute treatment of migraine headache?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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	7. Does the patient have a contraindication to, intolerability to, or has failed a trial of BOTH • **sumatriptan (Imitrex) nasal spray AND** • **Nurtec ODT or Ubrelvy tablet?**	☐ 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 _____

[15 Nov 2023]