Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Ubrelvy

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the requested drug being prescribed for the treatment of a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q2. Is the patient prescribed a dose and frequency that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Does the patient have a history of contraindication to the prescribed medication?

☐ Yes ☐ No

Q4. Is the requested medication being used for the acute treatment of migraine?

☐ Yes ☐ No

Q5. Has the patient been previously approved for Ubrelvy? If YES, go to 10.

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q6. Is the requested drug age-appropriate for the patient according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q7. Does the patient have a diagnosis confirmed according to the current International Headache Society Classification of Headache Disorders?

☐ Yes ☐ No

Q8. For the acute treatment of migraine, does the patient have ONE of the following:
a. A history of therapeutic failure of at least two (5-HT 1B/1D) receptor agonists (triptans) OR
b. Has a contraindication or intolerance to the preferred triptans

☐ Yes ☐ No

Q9. If currently using a different gepant, ONE of the following:
a. Will discontinue use of that gepant prior to starting the requested gepant OR
b. Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines.

☐ Yes ☐ No

Q10. For acute treatment, is documentation attached showing improvement in headache pain, symptoms, or duration?

☐ Yes ☐ No

Q11. For acute treatment of migraine, does the quantity exceed the quantity limit in place?

☐ Yes ☐ No

Q12. For a quantity exceeding the quantity limit in place, are all criteria guidelines are met?

☐ Yes ☐ No

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Q13. Is the drug is being prescribed by a neurologist or headache specialist who is certified in headache medicine by the UCNS?

☐ Yes ☐ No

Q14. Is the patient using the requested medication in addition to at least one medication for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody)?

☐ Yes ☐ No

Q15. Does the patient have a history of therapeutic failure, contraindication, or intolerance to all preventive migraine medications recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society)?

☐ Yes ☐ No

Q16. Is there documentation of an evaluation for the overuse of abortive medications, including opioids.

☐ Yes ☐ No

Q17. Additional Information:

_____ _____

Prescriber Signature Date

v2025