PRIOR AUTHORIZATION REQUEST

Journavx

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for a continuation of therapy?
[] Initial (If checked, go to question 2)

[] Continuation (If checked, deny)

2 What is the diagnosis or indication?
[] Acute mild pain (If checked, deny)

[] Acute moderate to severe pain (If checked, go to question 3)

If you have any questions, call: 1-888-258-8250

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	[] Chronic pain (If checked, deny)		
3	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
4	Has the patient had a trial and failure, intolerance to, or contraindication to TWO maximally tolerated non-steroidal anti-inflammatory drug (NSAID) products (for example, ibuprofen, naproxen, meloxicam, ketorolac) AND at least ONE acetaminophen containing product? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
5	Will Journavx (suzetrigine) be used concurrently with an opioid product? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
6	Has the patient had a trial and failure, intolerance to, or contraindication to at least THREE short-acting opioid products dosed at least 4 times per day for at least ten days each? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Is treatment duration for 14 days or less? [If no, no further questions.]	Yes	No
8	Has the patient been evaluated for drug-drug and drug-food interactions? [NOTE: Journavx (suzetrigine) should not be taken with strong CYP3A4 inhibitors.] [If no, no further questions.]	Yes	No
9	Is the patient currently taking a hormonal contraceptive containing progestins other than levonorgestrel and norethindrone? [If no, no further questions.]	Yes	No
10	Have additional nonhormonal contraceptives or alternative contraceptives been discussed with the patient and will be continued to be used during treatment with Journavx (suzetrigine) and 28 days after discontinuation?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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