Updated: 4/2025
PARP Approved: 5/2025

Prior Authorization Criteria

Journavx (suzetrigine)

All requests for Journavx (suzetrigine) require prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of moderate to severe acute pain and the following criteria is met:

- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- Documentation of a trial and failure or contraindication within the previous 30 days to ALL of the following:
    - acetaminophen
    - at least one NSAID
    - non-pharmacologic measures (e.g. rest, ice, heat)
- The episode of acute pain is anticipated to last less than one month
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- If suzetrigine (Journavx) has been used in the past the prescriber attests to both of the following:
    - Member is experiencing a new episode of moderate-to-severe acute pain, separate and distinct from the previous episode**.**
    - It has been at least 6 weeks since previous treatment with Journavx (suzetrigine)
- **Duration of Approval:** Up to a 14 days supply

HIGHMARK WHOLECARE

Updated: 4/2025
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Journavx (Suzetrigine)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION	
Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION		
Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION		
Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Billing Information
This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information	
Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)	
Diagnosis:	ICD Code:
☐ Yes ☐ No This episode of acute moderate to severe pain is anticipated to last less than one (1) month	
☐ Yes ☐ No Member has tried and failed or contraindications within the previous 30 days to all of the following: acetaminophen, NSAIDs, and non-pharmacologic measures	
☐ Yes ☐ No Prescription does not exceed 14 days supply	
If Journavx has been previously used:	
☐ Yes ☐ No Member is experiencing a new episode of moderate-to-severe acute pain, separate and distinct from the previous episode**.**	
☐ Yes ☐ No It has been at least 6 weeks since previous treatment with suzetrigine	
☐ Yes ☐ No The episode of acute pain is anticipated to last less than one (1) month	
☐ Yes ☐ No Member has tried and failed or contraindications within the previous 30 days to all of the following: acetaminophen, NSAIDs, and non-pharmacologic measures	
☐ Yes ☐ No Prescription does not exceed 14 days supply	

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

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Journavx (Suzetrigine)
PRIOR AUTHORIZATION FORM (CONTINUED)– PAGE 2 of 2

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MEMBER INFORMATION		
Member Name:	DOB:	
Member ID:	Member weight:	Height:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date