Journavx (Suzetrigine) no longer requires Prior Authorization effective 1/5/2026
Journavx is limited up to a 14 day supply (quantity max 29 tablets based on FDA approved dosing) and 1 prescription every 60 days.

HIGHMARK HEALTH OPTIONS

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 Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
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:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

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 the previous treatment with suzetrigine
☐ 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)

HIGHMARK HEALTH OPTIONS

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

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8:00am to 7:00pm

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date