HIGHMARK HEALTH OPTIONS

Updated: 04/2025
DMMA Approved: 05/2025

Request for Prior Authorization for Journavx(Suzetrigine)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Journavx require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Journavx (Suzetrigine) Prior Authorization Criteria:

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 Journavx (suzetrigine) 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 the previous treatment with Journavx (suzetrigine)
- **Duration of Approval:** Up to a 14 day supply

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary

References:

1. Journavx™ [package insert]. Boston, NJ; Vertex Pharmaceuticals Inc; January 2025
2. Institute for Clinical and Economic Review (ICER). Suzetrigine for Acute Pain: Effectiveness and Value. Final Policy Recommendations. March 31, 2025 https://icer.org/wp-content/uploads/2025/03/ICER_Acute-Pain_Final-Report_For-Publication_033125.pdf
3. Centers For disease Control and Prevention (CDC). U.S. Clinical Practice guideline for Prescribing Opioids for Pain, 2022. https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm

4. Centers For disease Control and Prevention (CDC). Overdose prevention: About prescription opioids. November1, 2024 Accessed March 8, 2025. https://www.cdc.gov/overdose-prevention/about/prescription-opioids.html
5. American Pain Society, American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and the American Society of Anesthesiologists' Committee on Regional Anesthesia, Executive Committee, and Administrative Council. Guidelines on the management of Postoperative Pain. Volume 17, Issue 2:131-57. February 2016.
6. Clinical Trials.gov. Evaluation of Efficacy and Safety of VX-548 for Acute Pain After an Abdominoplasty. Last update posted August 27,2024. Accessed March 7, 2025. https://www.clinicaltrials.gov/study/NCT05558410
7. Evaluation of Efficacy and Safety of VX-548 for Acute Pain After a Bunionectomy. Last update posted December 16,2024. Accessed March 7, 2025. https://www.clinicaltrials.gov/study/NCT05553366

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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 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)

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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