

Nurtec® ODT (Rimegepant) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy billing (NDC: _____) Start date (or date of next dose): _____

Dose: _____ Regimen: _____ Fill Quantity/Day Supply: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's medication history will be reviewed prior to approval.

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization:

1. What is the member's diagnosis?
 - Acute Treatment of Migraine in Adults
 - Preventative Treatment of Episodic Migraines in Adults
 - Other, please list: _____
2. If diagnosis is **Acute Treatment of Migraine in Adults**, please provide the following:
 - a. Will the member take Nurtec ODT concurrently with an injectable prophylactic calcitonin gene-related peptide (CGRP) inhibitor (e.g., Emgality®, Ajovy®, Aimovig®, Vyepti®)? Yes ___ No ___
 - b. Has the member failed at least 2 different triptan medications? Yes ___ No ___ If yes, please list:
 Medication _____ Date Span _____ Dosing _____
 Medication _____ Date Span _____ Dosing _____
 - c. If the member has no triptan trials, please provide a patient-specific, clinically significant reason why a triptan is not appropriate for the member: _____
3. If diagnosis is **Preventative Treatment of Episodic Migraines in Adults**, please provide the following (initial approvals will be for 3 months):
 - a. Does the member have documented:
 - Episodic Migraine Headaches
 - b. Date of member's episodic migraine diagnosis? _____
 - c. Number of episodic migraines per day, on average, for the past 3 months? _____
 - d. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated?
 - i. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes ___ No ___
 - ii. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes ___ No ___
 - e. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated?
 - i. Hormone replacement therapy or hormone-based contraceptives? Yes ___ No ___
 - ii. Chronic insomnia? Yes ___ No ___
 - iii. Obstructive sleep apnea? Yes ___ No ___
 - f. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes ___ No ___ If yes, please list:
 - i. Medication _____ Date Span _____ Dosing _____
 - ii. Medication _____ Date Span _____ Dosing _____
 - iii. Medication _____ Date Span _____ Dosing _____
 - g. If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s):
 Medication(s) _____
 Reason(s) for discontinuation prior to 8 weeks: _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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Nurtec® ODT (Rimegepant) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization for Preventative Treatment of Episodic Migraines in Adults (continued):

- h. Is the member taking any of the following medications known to cause medication overuse or rebound headaches... i. Decongestants... ii. Combination analgesics... iii. Opioid-containing medications... iv. Analgesic medications... v. Ergotamine-containing medications... vi. Triptans... i. Is the member taking any of the medications, listed in Question 11., known to cause medication overuse or rebound headaches... i. If yes, to any of the medication(s) listed... ii. If yes, to any of the medication(s) listed... j. Is the member taking any medications that are likely to be the cause of the headaches? Yes ___ No ___ k. Has the member been evaluated within the last 6 months by a neurologist... i. If yes, please include name of neurologist... l. Will member use Nurtec® ODT concurrently with botulinum toxin... m. If applicable, are other aggravating factors... n. Please provide a patient-specific, clinically significant reason why the member cannot use Emgality® (galcanezumab-nlml) or Ajoovy® (fremanezumab-vfrm):

For Continued Authorization (compliance and information regarding efficacy will be required for continued approval):

- 1. Has the member been compliant with Nurtec® ODT (rimegepant) treatment? Yes ___ No ___
2. Has the member responded well to treatment with Nurtec® ODT (rimegepant) ? Yes ___ No ___
3. Please provide the member's current number of migraine days per month: _____

Additional Information: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Please complete and return all pages. Failure to complete all pages will result in processing delays. Page 2 of 2

Table with 2 columns: PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: (University of Oklahoma College of Pharmacy, Pharmacy Management Consultants, Product Based Prior Authorization Unit, Fax: 1-800-224-4014, Phone: 1-800-522-0114 Option 4) and CONFIDENTIALITY NOTICE (This document, including any attachments, contains information which is confidential or privileged...)