

**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
  - Preventive 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 **Preventive 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 at 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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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 Preventive 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 h, known to cause medication overuse or rebound headaches... j. Is the member taking any medications that are likely to be the cause of the headaches? k. Has the member been evaluated within the last 6 months by a 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 Aimovig, Emgality, or Ajovy.

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? 2. Has the member responded well to treatment with Nurtec ODT (rimegepant)? 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...)