OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
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. Has the member been evaluated for red flags or possible indicators of secondary headache, as defined by the American Headache Society, and these conditions have been ruled out and/or have been treated? 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

OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
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 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 (alone or in combination products)? Yes☐ No☐
   ii. Combination analgesics containing caffeine and/or butalbital? Yes☐ No☐
   iii. Opioid-containing medications? Yes☐ No☐
   iv. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes☐ No☐
   v. Ergotamine-containing medications? Yes☐ No☐
   vi. Triptans? Yes☐ No☐

i. If the member is taking any of the medications listed in Question h please answer the following:
   a. List the medication(s) and the number of days per month taken: _____
   _____
   b. Are they taking the medication for an intractable condition known to cause chronic pain? Yes☐ No☐
      i. If yes, please provide the condition being treated: _____
      ii. If no, please provide additional information to support member's need for continued use of medication(s) known to cause overuse or rebound headaches: _____
      _____
      _____

j. Is the member taking any medications that are **likely** to be the cause of the headaches? Yes☐ No☐
k. Will member use Nurtec® ODT concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor? Yes☐ No☐
l. If applicable, are other aggravating factors that contribute to the development of episodic/chronic migraine headaches being treated (e.g., smoking)? Yes☐ No☐ Not Applicable☐
m. Please provide a patient-specific, clinically significant reason why the member cannot use Aimovig® (erenumab-aooe), Emgality® (galcanezumab-gnlm) or Ajovy® (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: _____

_____

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

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 PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*