

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:** _____

Pharmacy Information

Pharmacy NPI: _____ **Pharmacy Name:** _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

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 all of the following, as defined by the [American Headache Society](#), and these conditions have been ruled out and/or treated:
 - i. Red flags? Yes No
 - ii. Possible indicators of secondary headache? Yes No
 - iii. Medication overuse? Yes No

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Please complete and return all pages

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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Nurtec[®] ODT (rimegepant) Prior Authorization Form**Member Name:** _____ **Date of Birth:** _____ **Member ID#:** _____**Criteria****For Initial Authorization (continued):**

- e. 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
- f. Please provide a patient-specific, clinically significant reason (beyond convenience) why member cannot use 2 of the preferred CGRP inhibitors [i.e., Aimovig[®], Ajovy[®], Emgality[®]]:
- _____
- _____

For Continued Authorization:

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

Additional Information: _____

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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.

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