Nurtec ODT (rimegepant)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Acute Migraines □ Episodic Migraines □ Other diagnosis: _____ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Is taking Nurtec ODT (rimegepant) going to be part of a clinical trial? □ Yes □ No

<u>For diagnosis of Acute Migraines, please answer the following</u>:
Has patient had acute migraines for at least 1 year? □ Yes □ No

Has patient received at least two different triptans and failed to have relief of their acute migraine episodes? □ Yes □ No *Please submit documentation.*

Does the patient have an absolute contraindication to triptans: such as, ischemic heart disease, ischemic bowel disease, cerebrovascular disease, peripheral vascular disease, cardiac conduction pathway disorder, hemiplegic migraines, basilar migraines, or severe hepatic impairment? □ Yes □ No *Please submit documentation.*

Is the patient also using NurtecODT(rimegepant) for prevention of episodic migraines? □ Yes □ No

<u>For diagnosis of Prevention of Episodic Migraines, please answer the following</u>:

Has the patient had at least 4 migraine days per month? □ Yes □ No *Please submit chart documentation.*

Is the prescriber a neurologist or has UCNS accreditation in Headache Medicine? □ Yes □ No

Is the prescriber board certified in pain management? □ Yes □ No

Has the patient tried at least two(2) migraine preventive treatment categories? □ Yes □ No *Please submit chart documentation with dates of service.*

□ Beta Blocker

□ Anti-depressant

□ Anti-epileptic (excludes benzodiazepines)

□ Ca++Channel Blocker

Has the patient been evaluated for overuse headache due to triptans, ergot derivatives, opioid analgesics, non-opioid analgesics and combination products? □ Yes □ No

Is the patient also using Nurtec ODT (rimegepant) for treatment of acute migraines? □ Yes □ No

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811