

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](https://www.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:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> 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? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Acute Migraines <input type="checkbox"/> Episodic Migraines <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Will patient use in combination with another CGRP product for prevention and/or acute migraines? <input type="checkbox"/> Yes <input type="checkbox"/> No ---PATIENT IS NOT ALLOWED COMBINATION USE OF 2 CGRP'S OF ANY KIND-- If patient is using another CGRP product for acute or prevention of migraines and prescriber would like to use NurtecODT(rimegepant) for prevention or acute migraines, is prescriber ok with terming use of the other CGRP for acute or prevention of migraines in lieu of using NurtecODT(rimegepant) for prevention or acute migraines? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>*Any current active PA for an acute or prevention CGRP will be termed.</u> <u>For diagnosis of Acute Migraines, please answer the following:</u> Has patient had acute migraines for at least 1 year? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient received at least two different triptans and failed to have relief of their acute migraine episodes? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Is the patient also using NurtecODT(rimegepant) for <u>prevention of episodic migraines</u>? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit chart documentation.</i> Is the prescriber a neurologist or has UCNS accreditation in Headache Medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescriber board certified in pain management? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient tried at least two(2) migraine preventive treatment categories? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit chart documentation with dates of service.</i> <input type="checkbox"/> Beta Blocker		

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

- ☐ 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

---PATIENT IS NOT ALLOWED TO USE NURTEC ODT FOR BOTH PREVENTION AND ACUTE MIGRAINE TREATMENT---

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:** _____

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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