Zavzpret (zavegepant) **Prior Authorization Request Form**

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

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

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.

MEMBER INFORMATION			
LAST NAME:	FIRST NAM	E:	
PHONE NUMBER:	DATE OF BI	DATE OF BIRTH:	
STREET ADDRESS:	i		
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	:
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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		IF RENEWAL: DATE THERAPY	INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):				

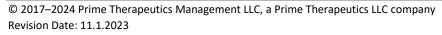
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MEMBER'S LAST NAME:	MEMBER'S FIRST I	NAME:		
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
 Acute migraine with or without aura Other diagnosis: 	ICD-10 Code(s):			
3. REQUIRED CLINICAL INFORMATION: PRIOR AUTHORIZATION.	PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A		
Is patient going to be using drug in a cl	linical trial? Yes No			
Does patient have extreme nausea and/or vomiting preventing them from taking their oral migraine medication? Yes INO <i>Please submit chart documentation</i> .				
Has patient tried and failed at least 2 o	oral triptans?	it chart documentation.		
 Does patient have one of the following absolute contraindications to triptans? Yes No Please check one AND provide chart documentation. Ischemic heart disease Ischemic bowel disease Cerebrovascular disease Peripheral vascular disease Cardiac conduction pathway disorder Hemiplegic migraines Basilar migraines				
Has patient tried and failed an oral calcitonin gene-related peptide receptor antagonist (CGRP)? Yes No Please submit chart documentation.				
Has patient tried at least one serotonin(5-HT) 1F receptor agonist(Reyvow(Lasmiditan)? Yes ON Please submit chart documentation.				
Does patient have an absolute contraindication to Reyvow(Lasmiditan)? Pes Do Please submit chart documentation.				
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?				





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MEMBER'S FIRST NAME: ____

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: _

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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 Phone: 877-228-7909

