PA Request Criteria

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218751

CAREFIRST ASO
CGRP Receptor Antagonists Oral Step Therapy

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of CGRP Receptor Antagonists Oral Step Therapy.

Patient Name: _____ **Date:** 10/14/2024
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (specify drug) _____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Is the request for Nurtec ODT, Ubrelvy, or Zavzpret being prescribed for the acute treatment of migraine in an adult patient?	**Y** ☐	**N** ☐
2.	Has the patient experienced an inadequate treatment response or an intolerance to two triptan 5-HT1 receptor agonists?	**Y** ☐	**N** ☐
3.	Does the patient have a contraindication that would prohibit a trial of triptan 5-HT1 receptor agonists?	**Y** ☐	**N** ☐
4.	Does the patient require MORE than the plan allowance of any of the following: A) Nurtec ODT or Ubrelvy 16 tablets per month, B) Zavzpret 6 nasal spray units per 3 weeks or 24 nasal spray units per 3 months?	**Y** ☐	**N** ☐
5.	Is the request for Nurtec ODT being prescribed for the preventive treatment of episodic migraine in an adult patient?	**Y** ☐	**N** ☐
6.	Is the request for Qulipta being prescribed for the preventive treatment of migraine in an adult patient?	**Y** ☐	**N** ☐
7.	Has the patient received at least 3 months of treatment with the requested drug?	**Y** ☐	**N** ☐
8.	Has the patient had a reduction in migraine days per month from baseline?	**Y** ☐	**N** ☐
9.	Does the patient require MORE than the plan allowance of any of the following: A) Nurtec ODT 16 tablets per month, B) Qulipta 30 tablets per month?	**Y** ☐	**N** ☐
10.	Does the patient require MORE than the plan allowance of any of the following: A) Nurtec ODT 16 tablets per month, B) Qulipta 30 tablets per month?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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