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## 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 Telephone:** \_\_\_\_\_  
**Physician Office Address:** \_\_\_\_\_  
**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 <input type="checkbox"/> | N <input type="checkbox"/> |
| 2. Has the patient experienced an inadequate treatment response or an intolerance to two triptan 5-HT <sub>1</sub> receptor agonists?  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 3. Does the patient have a contraindication that would prohibit a trial of triptan 5-HT <sub>1</sub> receptor agonists?  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 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 <input type="checkbox"/> | N <input type="checkbox"/> |
| 5. Is the request for Nurtec ODT being prescribed for the preventive treatment of episodic migraine in an adult patient?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 6. Is the request for Qulipta being prescribed for the preventive treatment of migraine in an adult patient?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 7. Has the patient received at least 3 months of treatment with the requested drug?  | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 8. Has the patient had a reduction in migraine days per month from baseline?   | Y <input type="checkbox"/> | N <input type="checkbox"/> |
| 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 <input type="checkbox"/> | N <input type="checkbox"/> |
| 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 <input type="checkbox"/> | N <input type="checkbox"/> |

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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