BlueCross BlueShield Federal Employee Program®

MIGRAINE CALCITONIN GENE-RELATED PEPTIDE PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

❑Ubrelvy Request: Complete PAGE 1 **❑Nurtec ODT Request: Complete PAGE 2**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

*****Non-covered branded medications must go through prior authorization and the formulary exception process**

NOTE: Form must be completed in its **entirety** for processing

1. **Please the select medication and answer the following questions:**

❑Ubrelvy (ubrogepant): Please select strength:

❑50mg: Will the patient need more than 96 tablets every 90 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ tablets every 90 days

❑100mg: Will the patient need more than 48 tablets every 90 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ tablets every 90 days

a. Is this request for brand or generic? ❑Brand ❑Generic

b. Which type of migraine does the patient have? ***Please select answer below:***

❑Migraine with aura (classic) ❑Migraine without aura (common) ❑Neither

c. Is this medication being used for the prevention of migraines or for acute treatment of migraines? ❑Yes* ❑No

If YES, please select answer below:

❑Prevention of migraines

❑Acute treatment of migraines, please answer the following questions:

i. Has the patient been on this medication continuously for the last **4 months** excluding samples? ❑Yes ❑No*

If NO, does the patient have an intolerance or contraindication to at least **TWO** triptan agents? ❑Yes ❑No*

If NO, has the patient completed an adequate 3-month trial to at least **TWO** triptan agents? ❑Yes ❑No

ii. Will the patient require TWO calcitonin gene-related peptide (CGRP) antagonist medications for migraine therapy? ***Please select answer below:***

❑ **YES**, Ubrelvy is for ACUTE treatment and will be used with another CGRP for ACUTE treatment of migraines (Nurtec, Zavzpret).

❑ **YES**, Ubrelvy is for ACUTE treatment and will be used with another CGRP for PREVENTATIVE treatment of migraines (Aimovig, Emgality, Ajovy, Qulipta, Vyepti, Nurtec). Acute and preventative CGRP combination therapy is covered if the patient is treatment resistant. **Please answer the below question:**

1) Has the patient completed an adequate 3-month trial of at least **TWO** of the following preventative CGRP antagonists: Aimovig, Ajovy, Emgality, Nurtec ODT, Qulipta, and/or Vyepti? ❑Yes ❑No*

If NO, has the patient completed an adequate 3-month trial of a triptan agent in combination with **ONE** of the preventative CGRP antagonists? ❑Yes ❑No

❑ **NO**, Ubrelvy is for ACUTE treatment and the patient will be stopping the current CGRP therapy.

❑ **NO**, Ubrelvy is the ONLY CGRP the patient will be using.

iii. Will this medication be used in combination with a triptan agent? ❑Yes* ❑No

If YES, please specify the medication: _____

PLEASE PROCEED TO PAGE 2 FOR NURTEC ODT REQUEST

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑**Nurtec ODT (rimegepant)**

a. Is this request for brand or generic? ❑Brand ❑Generic

b. Is this medication being used for the prevention of migraines or for acute treatment of migraines? ❑Yes* ❑No

If YES, please select answer below:

❑**Acute treatment of migraines** ***(typical dosing for acute treatment is one tablet daily as needed for migraine attacks)***, please answer the following questions:

i. Which type of migraine does the patient have? ***Please select answer below:***

❑Migraine with aura (classic) ❑Migraine without aura (common) ❑Neither

ii. Has the patient been on this medication continuously for the last **4 months** excluding samples? ❑Yes ❑No*

If NO, please answer the following questions:

a. Does the patient have an intolerance or contraindication to at least **TWO** triptan agents? ❑Yes ❑No*

If NO, has the patient completed an adequate 3-month trial to at least **TWO** triptan agents? ❑Yes ❑No

b. **Standard Option and Basic Option Patients**: Is this medication being requested as a change from Zavzpret to allow the member access to their copay benefit? ❑Yes ❑No

iii. Will the patient require TWO calcitonin gene-related peptide (CGRP) antagonist medications for migraine therapy? ***Please select answer below:***

❑ **YES**, Nurtec is for ACUTE treatment and will be used with another CGRP for ACUTE treatment of migraines (Ubrelvy, Zavzpret).

❑ **YES**, Nurtec is for ACUTE treatment and will be used with another CGRP for PREVENTATIVE treatment of migraines (Aimovig, Emgality, Ajovy, Qulipta, Vyepti). Acute and preventative CGRP combination therapy is covered if the patient is treatment resistant. **Please answer the below question:**

1) Has the patient completed an adequate 3-month trial of at least **TWO** of the following preventative CGRP antagonists: Aimovig, Ajovy, Emgality, Nurtec ODT, Qulipta, and/or Vyepti? ❑Yes ❑No*

If NO, has the patient completed an adequate 3-month trial of a triptan agent in combination with **ONE** of the preventative CGRP antagonists? ❑Yes ❑No

❑ **NO**, Nurtec is for ACUTE treatment and the patient will be stopping the current CGRP therapy.

❑ **NO**, Nurtec is the ONLY CGRP the patient will be using.

iv. Will this medication be used in combination with a triptan agent? ❑Yes* ❑No

If YES, please specify the medication: _____

vi. Will the patient need more than 56 tablets every 90 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ tablets per 90 days

❑**Prevention of migraines** ***(typical dosing for prevention is one tablet every other day)***, please answer the following questions:

i. Will Nurtec ODT be used as preventive treatment of **EPISODIC** migraines? ❑Yes ❑No

ii. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following question:

1) Has the patient taken a preventative CGRP medication in the past or is the patient switching from another preventative CGRP medication? ❑Yes ❑No*

If NO, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** of the following prophylactic agents: divalproex sodium/valproate sodium (Depakote/Depakote ER), topiramate (Topamax), amitriptyline (Elavil), nortriptyline (Pamelor), venlafaxine (Effexor), duloxetine (Cymbalta), or a beta-blocker such as atenolol, metoprolol, nadolol, propranolol, and timolol? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

1) Has the patient had a documented decrease in migraine days from baseline **OR** an improvement in daily activities due to the reduction of debilitating migraines? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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Patient Name: _____ DOB: _____ Patient ID: R _____

***Prevention of migraines* questions continued:**

iii. Will the patient require TWO calcitonin gene-related peptide (CGRP) antagonist medications for migraine therapy?
Please select answer below:

- ❑ **YES**, Nurtec is for PREVENTATIVE treatment and will be used with another CGRP for ACUTE treatment of migraines (Ubrelvy, Zavzpret). Acute and preventative CGRP combination therapy is covered if the patient is treatment resistant. **Please answer the below question:**
  1) Has the patient completed an adequate 3-month trial of at least **TWO** of the following preventative CGRP antagonists: Aimovig, Ajovy, Emgality, Nurtec ODT, Qulipta, and/or Vyepti? ❑Yes ❑No*****

     ****If NO***, has the patient completed an adequate 3-month trial of a triptan agent in combination with **ONE** of the preventative CGRP antagonists? ❑Yes ❑No
- ❑ **YES**, Nurtec is for PREVENTATIVE treatment and will be used with another CGRP for PREVENTATIVE Treatment of migraines (Aimovig, Emgality, Ajovy, Qulipta, Vyepti).
- ❑ **NO**, Nurtec is for PREVENTATIVE treatment and the patient will be stopping the current CGRP therapy.
- ❑ **NO**, Nurtec is the ONLY CGRP the patient will be using.

iv. Will the patient need more than 48 tablets every 90 days? ❑Yes***** ❑No
****If YES***, please specify the requested quantity: _____ tablets per 90 days