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

For Standard Option and Basic Option patients Nurtec ODT is the preferred product. Standard Option and Basic Option patients who switch to the preferred product can receive up to 2 fills without a copay in the benefit year.

Zavzpret (zavegepant)

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

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

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

1. Will the patient need more than 24 nasal spray devices every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ nasal spray devices every 90 days
2. **Standard Option and Basic Option Patients**: Would you like to participate in this program and switch the patient to Nurtec ODT? ***Please select answer below:***
   ❑**Yes, switch the patient to Nurtec ODT.**
   ❑**No**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Nurtec ODT? ❑Yes ❑No*
   If NO, is there a clinical reason for not trying Nurtec ODT ? ❑Yes ❑No
3. Will the patient require TWO calcitonin gene-related peptide (CGRP) antagonist medications for migraine therapy?
   Please select answer below:
   ❑ **YES**, Zavzpret is for ACUTE treatment and will be used with another CGRP for ACUTE treatment of migraines (Nurtec, Ubrelvy).
   ❑ **YES**, Zavzpret 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:**
      a. 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**, Zavzpret is for ACUTE treatment and the patient will be stopping the current CGRP therapy.
   ❑ **NO**, Zavzpret is the ONLY CGRP the patient will be using.
4. 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** 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, 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
      iii. Will this medication be used in combination with a triptan agent? ❑Yes* ❑No
      If YES, please specify the medication: _____
   ❑**Prevention of migraines**

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.