US Family Health Plan
Prior Authorization Request Form for
rimegepant orally disintegrating tablet sulfate (**Nurtec ODT**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007** **usfamilyhealth.org/rx-pa**

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient GREATER THAN or EQUAL to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have clinically significant or unstable cardiovascular disease?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Is the requested medication being prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of at least TWO of the following medications: sumatriptan (Imitrex), rizatriptan (Maxalt), zolmitriptan (Zomig), or eletriptan (Relpax)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Will the requested medication be used in combination with any other small molecule CGRP targeted medication (for example, another "gepant" or Ubrelvy)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

_____ _____
Prescriber Signature Date

[05 August 2020]