

USFHP 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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Initial approval expires after 6 months. For renewal of therapy, an initial Tricare prior authorization approval is required.

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

1

Patient Name: _____

Physician Name: _____

Address: _____

Address: _____

Sponsor ID #: _____

Phone #: _____

Date of Birth: _____

Secure Fax #: _____

Step 2 Please complete the clinical assessment:

2

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for Nurtec ODT.</i>	☐ Yes (subject to verification) Proceed to question 2	☐ No Proceed to question 6
2. What is the indication or diagnosis?	☐ For acute treatment – Proceed to question 3 ☐ For prevention of episodic migraine – Proceed to question 4 ☐ Other - STOP Coverage not approved	
3. Does the patient have a documented positive clinical response to therapy?	☐ Yes Sign and date below	☐ No STOP Coverage not approved
4. Has the patient had a reduction in mean monthly headache days of greater than or equal to 50% relative to the pretreatment baseline (as shown by patient diary documentation or healthcare provider attestation)?	☐ Yes Sign and date below	☐ No Proceed to question 5
5. Has the patient shown a clinically meaningful improvement in ANY of the following validated migraine-specific patient-reported outcome measures? ○ Migraine Disability Assessment (MIDAS) • Reduction of greater than or equal to 5 points when baseline score is 11–20? • Reduction of greater than or equal to 30% when baseline score is greater than 20 ○ Headache Impact Test (HIT-6): Reduction of greater than or equal to 5 points ○ Migraine Physical Functional Impact Diary (MPFID): Reduction of greater than or equal to 5 points	☐ Yes Sign and date below	☐ No STOP Coverage not approved

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6. Is the patient 18 years of age or older?	☐ Yes Proceed to question 7	☐ No STOP Coverage not approved
7. Is the requested medication being prescribed by or in consultation with a neurologist?	☐ Yes Proceed to question 8	☐ No STOP Coverage not approved
8. 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 Proceed to question 9
9. What is the indication or diagnosis?	☐ For acute treatment – Proceed to question 10 ☐ For prevention of episodic migraine – Proceed to question 12 ☐ Other - STOP Coverage not approved	
10. 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 11	☐ No STOP Coverage not approved
11. Does the patient have a contraindication to, intolerability to, OR has failed a trial of Ubrelvy?	☐ Yes Sign and date below	☐ No STOP Coverage not approved
12. Does the patient have episodic migraines at a rate of 4 to 7 migraine days per month for 3 months and has at least moderate disability shown by Migraine Disability Assessment (MIDAS) Test score greater than 11 or Headache Impact Test-6 (HIT-6) score greater than 50?	☐ Yes Proceed to question 14	☐ No Proceed to question 13
13. Does the patient have episodic migraine at a rate of at least 8 migraine days per month for 3 months?	☐ Yes Proceed to question 14	☐ No STOP Coverage not approved
14. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of at least ONE drug from TWO of the following migraine prophylactic drug classes: ○ Prophylactic antiepileptic medications: valproate, divalproic acid, topiramate ○ Prophylactic beta-blocker medications: metoprolol, propranolol, atenolol, nadolol, timolol ○ Prophylactic antidepressants: amitriptyline, duloxetine, nortriptyline, venlafaxine?	☐ Yes Proceed to question 15	☐ No STOP Coverage not approved
15. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of at least ONE of the following CGRP injectable agents: ○ erenumab-aooe (Aimovig) ○ fremanezumab-vfrm (Ajovy) ○ galcanezumab-gnlm (Emgality)?	☐ Yes Proceed to question 16	☐ No STOP Coverage not approved

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16. Does the patient have a contraindication to, intolerability to, or has failed a 2-month trial of Qulipta?	☐ Yes Sign and date below	☐ No Proceed to question 17
17. Is the patient currently stable on Nurtec ODT for prevention of episodic migraine? <u>Please note:</u> If the patient is currently stable on Nurtec ODT for prevention of episodic migraine, then a trial of Qulipta is not required if a new PA is submitted.	☐ Yes Sign and date below	☐ No STOP Coverage not approved

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

Prescriber Signature

Date

[21 May 2026]