# 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**

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

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

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

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

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| 1. **Is the patient GREATER THAN or EQUAL to 18 years of age?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Is the requested medication being prescribed by or in consultation with a neurologist?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Will the requested medication be used in combination with any other small molecule CGRP targeted medication (for example, another "gepant" or Ubrelvy)?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **4** |
| **4. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Nurtec ODT.*** | ☐ Yes<br>(subject to verification)<br>Proceed to question **5** | ☐ No<br>Proceed to question **9** |
| **5. What is the indication or diagnosis?** | ☐ For acute treatment – Proceed to question **6**<br>☐ For prevention of episodic migraine – Proceed to question **7**<br>☐ Other - **STOP Coverage not approved** | |
| **6. Does the patient have a documented positive clinical response to therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **7. 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<br>**Sign and date below** | ☐ No<br>Proceed to question **8** |

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| **8. Has the patient shown a clinically meaningful improvement in ANY of the following validated migraine-specific patient-reported outcome measures?**<br>○ **Migraine Disability Assessment (MIDAS)**<br>• **Reduction of greater than or equal to 5 points when baseline score is 11–20?**<br>• **Reduction of greater than or equal to 30% when baseline score is greater than 20**<br>○ **Headache Impact Test (HIT-6): Reduction of greater than or equal to 5 points**<br>○ **Migraine Physical Functional Impact Diary (MPFID): Reduction of greater than or equal to 5 points** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. What is the indication or diagnosis?** | ☐ For acute treatment – Proceed to question **10**<br>☐ For prevention of episodic migraine – Proceed to question **11**<br>☐ 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<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **11. 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<br>Proceed to question **13** | ☐ No<br>Proceed to question **12** |
| **12. Does the patient have episodic migraine at a rate of at least 8 migraine days per month for 3 months?** | ☐ Yes<br>Proceed to question **13** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **13. 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:**<br>○ **Prophylactic antiepileptic medications: valproate, divalproic acid, topiramate**<br>○ **Prophylactic beta-blocker medications: metoprolol, propranolol, atenolol, nadolol, timolol**<br>○ **Prophylactic antidepressants: amitriptyline, duloxetine, nortriptyline, venlafaxine?** | ☐ Yes<br>Proceed to question **14** | ☐ No<br>**STOP**<br>**Coverage not approved** |

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| **14. 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:**<br>○ **erenumab-aooe (Aimovig)**<br>○ **fremanezumab-vfrm (Ajovy)**<br>○ **galcanezumab-gnlm (Emgality)?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3**

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

_____ _____
Prescriber Signature Date

[31 August 2022]