CAREFIRST
CGRP Receptor Antagonists Oral Step Therapy

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of CGRP Receptor Antagonists Oral Step Therapy.

Patient Information

Patient Name:
Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐
Patient ID:
Patient Group:
Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name
Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐
Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐
Physician Addr.:
City, St, Zip:

Drug Name (select from list of drugs shown)

Ubrelvy 50mg Tablets (ubrogepant) Ubrelvy 100mg Tablets (ubrogepant) Qulipta 60mg Tablet (atogepant) Qulipta 30mg Tablet (atogepant) Qulipta 10mg Tablet (atogepant) Nurtec ODT 75mg (rimegepant)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Is the request for Nurtec ODT or Ubrelvy being prescribed for the acute treatment of migraine in an adult patient?	**Y** ☐	**N** ☐
2.	Has the patient experienced an inadequate treatment response or an intolerance to two triptan 5-HT1 receptor agonists?	**Y** ☐	**N** ☐
3.	Does the patient have a contraindication that would prohibit a trial of triptan 5-HT1 receptor agonists?	**Y** ☐	**N** ☐
4.	Will the requested drug be used concurrently with another CGRP receptor antagonist?	**Y** ☐	**N** ☐
5.	Does the patient require more than the plan allowance of 16 tablets per month?	**Y** ☐	**N** ☐
6.	Is the request for Nurtec ODT or Qulipta being prescribed for the preventive treatment of episodic migraine in an adult patient?	**Y** ☐	**N** ☐
7.	Will the requested drug be used concurrently with another CGRP receptor antagonist?	**Y** ☐	**N** ☐
8.	Has the patient received at least 3 months of treatment with the requested drug?	**Y** ☐	**N** ☐
9.	Has the patient had a reduction in migraine days per month from baseline?	**Y** ☐	**N** ☐
10.	Does the patient require more than the plan allowance of any of the following: A) Nurtec ODT 16 tablets per month, B) Qulipta 30 tablets per month?	**Y** ☐	**N** ☐
11.	Has the patient experienced an inadequate treatment response with an 8-week trial of any of the following: A) Antiepileptic drugs (AEDs), B) Beta-adrenergic blocking agents, C) Antidepressants?	**Y** ☐	**N** ☐

12.	Has the patient experienced an intolerance or does the patient have a contraindication that would prohibit an 8-week trial of any of the following: A) Antiepileptic drugs (AEDs), B) Beta-adrenergic blocking agents, C) Antidepressants?	**Y** ☐	**N** ☐
13.	Is this request for Qulipta?	**Y** ☐	**N** ☐
14.	Does the patient require more than the plan allowance of 30 tablets per month?	**Y** ☐	**N** ☐
15.	Does the patient require more than the plan allowance of 16 tablets per month?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date