CAREFIRST MD
Reyvow 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 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Reyvow 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)

Reyvow 50mg Tablets (lasmiditan) Reyvow 100mg Tablets (lasmiditan)

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 requested drug being prescribed for the acute treatment of migraine with or without aura 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.	Does the patient require MORE than the plan allowance PER MONTH of any of the following: A) 4 tablets of Reyvow 50 mg or 200 mg, B) 8 tablets of Reyvow 100 mg?	**Y** ☐	**N** ☐
5.	Has medication overuse headache been considered and ruled out?	**Y** ☐	**N** ☐
6.	Is the patient currently using migraine prophylactic therapy?	**Y** ☐	**N** ☐
7.	Is the patient unable to take migraine prophylactic therapy due to an inadequate treatment response, intolerance, or contraindication?	**Y** ☐	**N** ☐
8.	Does the patient require MORE than the plan allowance PER MONTH of any of the following: A) 8 tablets of Reyvow 50 mg or 200 mg, B) 16 tablets of Reyvow 100 mg?	**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.

_____

Prescriber (Or Authorized) Signature and Date