TRICARE Prior Authorization Request Form for
rimegepant orally disintegrating tablet sulfate (Nurtec ODT)

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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):

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. **Is the requested medication being prescribed by or in consultation with a neurologist?**	☐ Yes Proceed to question **3**	☐ No **STOP** **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 **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. **Has the patient received this medication under the TRICARE benefit in the last 6 months?** ***Please choose "No"*** *if the patient did not previously have a TRICARE approved PA for Nurtec ODT.*	☐ Yes (subject to verification) Proceed to question **5**	☐ No Proceed to question **9**
5. **What is the indication or diagnosis?**	☐ For acute treatment – Proceed to question **6** ☐ For prevention of episodic migraine – Proceed to question **7** ☐ Other - **STOP Coverage not approved**	
6. **Does the patient have a documented positive clinical response to therapy?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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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 **Sign and date below**	☐ No Proceed to question **8**
8. 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**
9. What is the indication or diagnosis?	☐ For acute treatment – Proceed to question **10** ☐ For prevention of episodic migraine – Proceed to question **11** ☐ 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 **Sign and date below**	☐ No **STOP** **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 Proceed to question **13**	☐ No 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 Proceed to question **13**	☐ No **STOP** **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: ○ **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 **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 of the following CGRP injectable agents: ○ **erenumab-aooe (Aimovig)** ○ **fremanezumab-vfrm (Ajovy)** ○ **galcanezumab-gnlm (Emgality)?**	☐ 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 _____

[31 August 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: