Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
REYVOW (lasmiditan succinate) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 4 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage **REYVOW (lasmiditan succinate).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a Neurologist or Pain Management Specialist with expertise in diagnosis/treating headaches? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, start date: _____

2. Indicate the Member's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the medication being prescribed for the treatment of acute migraine?
   □ No □ Yes

2. Does the patient have documented trial (≥ 2 months) with treatment failure, or inadequate response, to at least 3 generic oral triptan agents at maximally tolerated doses?
   □ No □ Yes

3. Has the patient failed or has contraindication to Ubrelvy (ubrogepant)?
   □ No □ Yes

For Continuation of Therapy, Please Respond to <u>Additional Questions</u> Below:

1. Does the patient meet all the initial criteria for coverage?
   □ No □ Yes

2. After 3 months of treatment, does the patient have evidence of positive clinical response?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**