



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.  
NURTEC (rimegepant sulfate) 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 **NURTEC (rimegepant sulfate)**. 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:

#### **Treatment of acute migraine:**

1. Does the patient have a documented trial ( $\geq 2$  months) with treatment failure, or inadequate response, to at least 3 generic oral triptan agents at maximally tolerated doses?  
 No  Yes
2. Has the patient failed or has contraindication to Ubrovelvy (ubrogepant)?  
 No  Yes

#### **Prevention of episodic migraine:**

1. Has the patient had  $\geq 4$  and  $< 15$  migraine headache days per month (prior to initiating a migraine-preventative medication)?  
 No  Yes
2. Has the patient had a documented trial ( $\geq 2$  months) with treatment failure, inadequate response, or contraindication to use to at least 3 preventative agents for migraine, **2 of which must include:**
  - Tricyclic antidepressants (e.g., amitriptyline, nortriptyline)
  - Beta-blocker (e.g., metoprolol, propranolol)
  - SNRIs (e.g., venlafaxine, duloxetine)
  - Candesartan
  - Lisinopril
  - Topiramate
  - Valproate No  Yes
3. Has the patient had a trial of 2 injectable CGRP antagonists (Ajovy preferred, then Emgality, then Aimovig) AND Qulipta (atogepant)?  
 No  Yes
4. If the patient is on opioids or barbiturates, is use  $\leq 4$  days in the month prior to initiation?  
 No  Yes  N/A, patient not on opioids or barbiturates
5. Does the patient's BMI fall between 18 to 40?  
 No  Yes

#### **For Continuation of Therapy, Please Respond to Additional Questions Below:**

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

2. After 3 months of treatment, does patient have evidence of positive clinical response?

No  Yes

Notes:

*\*Limit quantity of Nurtec to 8 tablets per 30 days when used for the treatment of acute migraine*

*\*\*For either indication, patient should not use in combination with another CGRP antagonist Ajovy (fremanezumab-vfrm), Emgality (galcanezumab-gnlm), Aimovig (erenumab-aooe) or Vyepti (eptinezumab). CGRP inhibitors for migraine prevention have not been studied for use in combination with another agent in the same class. The clinical trial of Nurtec ODT for the preventive treatment of episodic migraine did not permit the use of a concomitant medication that acts on the CGRP pathway.*

**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:**

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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