carolina complete health

Pharmacy Prior Approval Request for
Migraine Calcitonin Agents: ACUTE Treatment -Ubrelvy and Nurtec

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____
Address_____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

For initial and reauthorization requests, please answer questions 1-6:

1. Is the Beneficiary 18 years of age or older? ☐ **Yes** ☐ **No**
2. Does the Beneficiary have a diagnosis of migraine, with or without aura? ☐ **Yes** ☐ **No**
3. Does the Beneficiary have a headache frequency of 15 or more headache days per month over the past 6 months? ☐ **Yes** ☐ **No**
4. Will the Beneficiary use Ubrelvy/Nurtec concurrently with a strong CYP3A4 inhibitor? ☐ **Yes** ☐ **No**
5. Does the Beneficiary have end-stage renal disease with a creatinine clearance (CrCl) less than 15ml/min? ☐ **Yes** ☐ **No**
6. Has the Beneficiary tried and failed, or have a contraindication to 2 or more preferred Triptans ☐ **Yes** ☐ **No**

For reauthorization, please answer questions 1-9:

7. Beneficiary must continue to meet the above criteria. Have questions 1-6 been answered? ☐ **Yes** ☐ **No**
8. Does the Beneficiary demonstrate resolution in headache pain or reduction in headache severity, as assessed by prescriber? ☐ **Yes** ☐ **No**
9. Has the Beneficiary experience any treatment-restricting adverse effects (e.g.: nausea, somnolence, dry mouth)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/