Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Calcitonin gene-related peptide (CGRP) Antagonists: rimegepant (NURTEC)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. The requested medication is prescribed for ONE (1) of the following:

- ◯ Acute or as needed treatment of migraine headaches
  (Go to #8)
- ◯ Prophylaxis or long-term prevention of migraine headaches
  (Go to #15)
- ◯ Other
  (Go to #7)

7. If being prescribed for an indication not listed above, please provide any additional clinical information important to this review.
(Go to #23)

Acute or As Needed Use Only Clinical Criteria

8. Is the member greater than or equal to (≥) 18 years of age?

- ◯ Yes
  (Go to #9)
- ◯ No (Deny)
  (Go to #9)

9. Does the member have a diagnosis of migraine headache in the last 730 days?

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

10. Does the member have an approved prior authorization for rimegepant (NURTEC) or ubrogepant (UBRELVY) in the last 365 days?

- ◯ Yes
  (Go to #12)
- ◯ No
  (Go to #11)

11. Has the member tried and failed therapy with at least TWO (2) different triptans, or does the member have a contraindication to triptan therapy?

Examples of triptans include: almotriptan malate, eletriptan hydrobromide (RELPAX), frovatriptan succinate (FROVA), naratriptan HCL (AMERGE), rizatriptan (MAXALT), sumatriptan (IMITREX, ONZETRA XSAIL, ZEMBRACE SYMTOUCH, TREXIMET), and zolmitriptan (ZOMIG).

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

12. Does the member have a diagnosis of severe hepatic impairment in the last 365 days?

- ◯ Yes (Deny)
  (Go to #13)
- ◯ No
  (Go to #13)

13. Does the member have a claim for a contraindicated drug in the last 30 days?

Examples of contraindicated drugs include: amiodarone (PACERONE), APTIOM, atazanavir sulfate (REYATAZ), ATRIPLA, bexarotene (TARGRETIN), bosentan (TRACLEER), carbamazepine (CARBATROL ER, EPITOL, EQUETRO, TEGRETOL, TEGRETOL XR), carvedilol (COREG), carvedilol ER (COREG CR), clarithromycin, clarithromycin ER, CRIXIVAN, cyclosporine (GENGRAF, NEORAL), efavirenz (SUSTIVA), EVOTAZ, GENVOYA, INTELENCE, INVIRASE, itraconazole (SPORANOX, TOLSURA), KALETRA, ketoconazole, KORLYM, modafinil (PROVIGIL), MULTAQ, NOXAFIL, ORKAMBI, phenytoin (DILANTIN), phenobarbital, primidone, PROMACTA, ranolazine (RANEXA), verapamil (CALAN), voriconazole (VFEND), and others.

- ◯ Yes (Deny)
  (Go to #14)
- ◯ No
  (Go to #14)

14. Is the requested quantity greater than (>) 16 tablets in 30 days?

- ◯ Yes (Deny)
  (Go to #23)
- ◯ No (Approve - 90 days)
  (Go to #23)

Prophylaxis or Long-term Preventive Use Only Clinical Criteria

15. Is this a renewal request?

- ◯ Yes
  (Go to #19)
- ◯ No
  (Go to #16)

16. Is the member greater than or equal to (≥) 18 years of age?

- ◯ Yes
  (Go to #17)
- ◯ No (Deny)
  (Go to #17)

17. Does the member have a diagnosis of episodic migraines (defined as having between four (4) and 14 migraine days per month and less than (<) 15 headache days per month on average in the last 90 days)? [Manual]

- ◯ Yes
  (Go to #18)
- ◯ No (Deny)
  (Go to #18)

18. Does the member have a history of a 60-day trial of two (2) or more migraine prophylactic therapies in the last 365 days?

Examples of migraine prophylactic therapyies include: amitriptyline, atenolol (TENORMIN), divalproex (DEPAKOTE), metoprolol (TOPROL XL), nadolol, propranolol (INDERAL LA, INNOPRAN XL), timolol, topiramate (QUDEXY XR, TOPAMAX, TROKENDI XR), and venlafaxine (EFFEXOR XR). This is based on the American Academy of Neurology (AAN) and American Headache Society (AHS) 2012/2015 treatment guidelines. All drugs listed have a rating of "Strong Evidence (Level A and B)" for prevention of migraine headaches.

◯ Yes
(Go to #19)

◯ No (Deny)
(Go to #19)

19. Is the requested quantity less than or equal to the recommended dosing guidelines?

- Recommended Dose: 75 mg every other day
- Allowable Quantity: less than or equal to (≤) 18 tablets/month

◯ Yes
(Go to #20)

◯ No (Deny)
(Go to #20)

20. Does the member have a diagnosis of severe hepatic impairment in the last 365 days?

◯ Yes (Deny)
(Go to #21)

◯ No
(Go to #21)

21. Does the member have a claim for a contraindicated drug in the last 30 days?

Examples of contraindicated drugs include: amiodarone (PACERONE), APTIOM, atazanavir sulfate (REYATAZ), ATRIPLA, bexarotene (TARGRETIN), bosentan (TRACLEER), carbamazepine (CARBATROL ER, EPITOL, EQUETRO, TEGRETOL, TEGRETOL XR), carvedilol (COREG), carvedilol ER (COREG CR), clarithromycin, clarithromycin ER, CRIXIVAN, cyclosporine (GENGRAF, NEORAL), efavirenz (SUSTIVA), EVOTAZ, GENVOYA, INTELENCE, INVIRASE, itraconazole (SPORANOX, TOLSURA), KALETRA, ketoconazole, KORLYM, modafinil (PROVIGIL), MULTAQ, NOXAFIL, ORKAMBI, phenytoin (DILANTIN), phenobarbital, primidone, PROMACTA, ranolazine (RANEXA), verapamil (CALAN), voriconazole (VFEND), and others.

◯ Yes (Deny)
(Go to #22)

◯ No
(Go to #22)

22. Will the member have concurrent therapy with another CGRP antagonist for prophylaxis of migraines?

Examples of CGRP antagonist include: erenumab (AIMOVIG), fremanezumab (AJOVY), galcanezumab (EMGALITY), and atogepant (QULIPTA).

◯ Yes (Deny)
(Go to #23)

◯ No (Approve - 365 days)
(Go to #23)

Additional Information

23. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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