TEXAS MEDICAID
Clinical Edit Prior Authorization
rimegepant (NURTEC)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the medication being prescribed by, or in consultation with, a Neurologist, pain specialist or headache specialist; or has the client been seen in the emergency room for treatment of migraine; or has the client had imaging tests for migraine? [Manual Step]

   ☐ Yes (Go to #2) ☐ No (Deny)

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

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a diagnosis of migraine headache in the last 730 days?

   ☐ Yes (Go to #4) ☐ No (Deny)

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

   ☐ Yes (Go to #6) ☐ No (Go to #5)

5. Has the client tried and failed therapy with at least 2 different triptans, or does the client 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 #6) ☐ No (Deny)

6. Does the client have a diagnosis of severe hepatic impairment in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #7)

7. Does the client have a claim for a contraindicated drug in the last 30 days?

   Examples of contraindicated drugs include amiodarone HCl, APTIOM, atazanavir sulfate (REYATAZ), ATRIPLA, bexarotene (TARGRETIN), bosentan (TRACLEER), carbamazepine (CARBATROL ER, EPITOL, TEGRETOL, TEGRETOL XR), carvedilol (COREG), carvedilol ER (COREG CR), clarithromycin, clarithromycin ER, CRIXIVAN, cyclosporine (GENGRAF, NEORAL), EQUETRO, phenytoin (DILANTIN), efavirenz (SUSTIVA), EVOTAZ, GENVOYA, INTELENCE, INVIRASE, itraconazole (SPORANOX), KALETRA, ketoconazole, KORLYM, verapamil (CALAN), and others.

   ☐ Yes (Deny) ☐ No (Go to #8)

8. Is the requested quantity greater than 16 tablets in 30 days?

   ☐ Yes (Deny) ☐ No (Approve – 90 days)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.