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 for Acute Treatment: ubrogepant (UBRELVY)

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)

Clinical Criteria (required)

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

   Yes
   (Go to #7)

   No (Deny)
   (Go to #7)

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

   Yes
   (Go to #8)

   No (Deny)
   (Go to #8)

8. Does the member have a paid claim for rimegepant (NURTEC) or ubrogepant (UBRELVY) in the last 365 days?

   Yes
   (Go to #10)

   No
   (Go to #9)

9. 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 #10)

   No (Deny)
   (Go to #10)

10. Does the member have a diagnosis of end stage renal disease (ESRD) in the last 365 days?

    Yes (Deny)
    (Go to #11)

    No
    (Go to #11)

11. Does the member have a claim for a strong CYP3A4 inhibitor or inducer in the last 30 days?

Examples include atazanavir sulfate (REYATAZ), bexarotene, carbamazepine (TEGRETOL, EPITOL) carbamazepine ER (TEGRETOL XR, CARBATROL ER), clarithromycin, clarithromycin ER, CRIXIVAN, EQUETRO, EVOTAZ, GENVOYA, INVIRASE, itraconazole (SPORANOX), KALETRA, ketoconazole, KORLYM, lansoprazole-amoxicillin-clarithromycin, LYSODREN, primidone (MYSOLINE), nefazodone, ritonavir (NORVIR), NOXAFIL, OMECLAMOX-PAK, ORKAMBI, phenobarbital, phenytek, phenytoin (DILANTIN), PREZCOBIX, PREZISTA, rifampin (RIFADIN, RIFAMATE, RIFATER), STRIBILD, SYMTUZA, TOLSURA, TYBOST, voriconazole (VFEND), VIEKIRA PAK, VIRACEPT, XTANDI, and ZYDELIG

Yes (Deny)
(Go to #12)

No
(Go to #12)

12. Is the requested quantity greater than (>) 20 tablets in 30 days?

Yes (Deny)
(Go to #13)

No (Approve - 90 days)
(Go to #13)

Additional Information

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

Submission Information (required)

Prescriber Signature: ____ **Date:** _______________

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