AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – 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. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___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 old 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 or 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 the prescriber? Yes___ No___
9. Has the beneficiary experienced 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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406