Montana Healthcare Programs Prior Authorization Request Form for Use of Oral CGRP Inhibitors and Reyvow™

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
<td>Prescriber Phone:</td>
<td>Prescriber Fax:</td>
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<tr>
<td>Prescriber Name:</td>
<td>Prescriber Specialty (if applicable):</td>
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<tr>
<th>Requested Drug:</th>
<th>Dose:</th>
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<tbody>
<tr>
<td>Nurtec ODT</td>
<td>Reyvow</td>
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Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:

**INITIATION OF THERAPY**

Please check appropriate diagnosis:

- **Acute Migraine** (Applies only to Nurtec ODT, Reyvow, and Ubrelvy)
- **Episodic Migraine Prophylaxis** (Applies to Nurtec ODT and Qulipta only: 4-14 migraine days/month AND <15 headache days/month)

**Acute Migraine Therapy**

- Member is 18 years of age or older
- Member must have an inadequate response, contraindication, or intolerance to at least two different triptan medications:
  - Drug Name: ___________________________ Dates used: ___________________________
  - Drug Name: ___________________________ Dates used: ___________________________

- Member must currently be using a prophylactic medication (oral therapy, Botox, etc) unless contraindicated, not tolerated or ineffective (Note: for Nurtec ODT or Ubrelvy, member CAN-NOT be on an injectable CGRP therapy):
  - Yes – Therapy Name: ____________________________________________________________
  - No – Explanation Required: ____________________________________________________

**Episodic Migraine Prophylaxis (applies only to Nurtec ODT and Qulipta)**

- Member is 18 years of age or older
- If medication is non-preferred (please refer to the Montana Medicaid Preferred Drug List for current preferred options), member has had an inadequate response, contraindication or intolerance to a **preferred** oral or injectable CGRP therapy that is indicated for migraine prophylaxis: □ Yes  □ No  □ N/A, Med is preferred
  - Drug Name: ___________________________ Date Used: _____________________________
  - Reason for discontinuation: _____________________________________________________
☐ Provider attests that this therapy is being used as a preventative therapy, not for treatment of acute migraine attack, AND member will not be concomitantly using an injectable CGRP therapy.

☐ Member has a history of inadequate response (trial of at least 2 months duration), contraindication or intolerance to 2 prophylactic conventional therapies (must include at least 2 separate therapeutic classes) from the following (please circle what has been trialed):

<table>
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<tr>
<th>Drug (please circle applicable drugs trialed)</th>
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<tr>
<td>Amitriptyline or venlafaxine</td>
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<td>Atenolol, metoprolol, nadolol or propranolol</td>
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<td>Topiramate or divalproex</td>
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**Quantity Limitations:**
Nurtec ODT: 18 doses per month for acute migraine therapy/15 doses per month for prophylactic therapy
Quiligta: 1 tablet daily
Reyvow: 4 doses per month
Ubrelvy: 16 doses per month

Initial authorization will be issued for 3 months.

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**CONTINUATION OF THERAPY**

☐ Member has experienced a positive response to therapy as demonstrated by a reduction in migraine frequency compared to number of migraine days at baseline has been chart documented: ☐ Yes ☐ No

For acute migraine therapy, member is still currently taking a prophylactic therapy: ☐ Yes ☐ No

- ACTION REQUIRED – Please indicate the current prophylactic therapy: ______________________________

Reauthorization will be issued for 12 months.

Please complete form, including required attachments and fax to:
1-800-294-1350

11/2021