Mountain Pacific
INNOVATING BETTER HEALTH

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

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	Prescriber Fax:
Prescriber Name:	Prescriber Specialty (if applicable):	
Requested Drug: ☐ Nurtec ODT ☐ Reyvow ☐ Ubrelvy ☐ Qulipta *(Approval subject to preferred drug list requirements)*	Dose:	

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)
- ☐ **Chronic Migraine Prophylaxis** (Applies only to Qulipta)

1. Acute Migraine Therapy

a. Member is 18 years of age or older: ☐ Yes ☐ No

b. Member must have an inadequate response, contraindication or intolerance to at least two different triptan medications:

Drug name: _____ Dates used: _____

Drug name: _____ Dates used: _____

c. 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 CANNOT be on an injectable calcitonin gene-related peptide [CGRP] therapy):

- ☐ Yes - Therapy name: _____
- ☐ No - Explanation required: _____

2. Episodic Migraine Prophylaxis (applies only to Nurtec ODT and Qulipta) or Chronic Migraine Prophylaxis (applies only to Qulipta)

a. Member is 18 years of age or older: ☐ Yes ☐ No

b. If medication is nonpreferred (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 an injectable CGRP therapy indicated for migraine prophylaxis: ☐ Yes ☐ No ☐ N/A - Drug is preferred.

Drug name: _____ Dates used: _____

Reason for discontinuation: _____

c. Initial baseline number of headaches per month: _____

d. Provider attests this therapy is being used as a preventative therapy, not for treatment of acute migraine attack: ☐ Yes ☐ No

e. Provider attests member will not be concomitantly using with other CGRP therapies: ☐ Yes ☐ No

f. 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):

Drug (please circle applicable drugs trialed)
Amitriptyline or venlafaxine
Atenolol, metoprolol, nadolol or propranolol
Topiramate or divalproex

Quantity Limitations:

- Nurtec ODT: 8 doses per month for acute migraine therapy/15 doses per month for prophylactic therapy
- Qulipta: 1 tablet daily
- Reyvow: 4 doses per month
- Ubrelvy: 16 doses per month

Initial authorization will be issued for 12 months.

☐ CONTINUATION OF THERAPY

1. Member has experienced a positive response to therapy as demonstrated by a reduction in migraine frequency compared to number of migraine days at baseline and has been chart documented: ☐ Yes ☐ No
2. Provider attests this therapy is being used as a preventative therapy, not for treatment of acute migraine attack: ☐ Yes ☐ No
3. Provider attests member will not be concomitantly using with other CGRP therapies: ☐ 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

10/2023