Mountain Pacific
INNOVATING BETTER HEALTH
Mailing Address: P.O. Box 5119 | Helena, MT 59604
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Fax: 406.513.1928 | Toll-free: 1.800.294.1350

Montana Healthcare Programs Prior Authorization Request Form for Use of Nasal CGRP Inhibitors

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	Prescriber Fax:
Prescriber Name:	Prescriber Specialty (if applicable):	
Requested Drug: ☐ Zavzpret® *(Approval subject to preferred drug list requirements)*	Dose:	

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has diagnosis of acute migraine with or without aura: ☐ Yes ☐ No
3. Member must currently be using a prophylactic medication (oral therapy, Botox, etc.) unless contraindicated, not tolerated or ineffective (Note: member CANNOT be on an oral or injectable calcitonin gene-related peptide [CGRP] therapy for preventative therapy):
   - ☐ Yes - Therapy name: _____
   - ☐ No - Explanation required: _____
4. Member must have an inadequate response, contraindication or intolerance to **at least** two (2) different triptan 5-HT1 receptor agonists, **ONE** of which must be a nasal formulation:

   Drug name: _____ Dates used: _____

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5. If nonpreferred, member has had a trial and inadequate response or contraindication to a preferred drug with the same indication and the same mechanism of action (CGRP receptor antagonist) from the Montana Healthcare Programs Preferred Drug List 19 (mt.gov).

   Drug name: _____ Dates used: _____
6. Provider attests Zavzpret® is being used for acute treatment of migraine and not for preventative treatment of migraine: ☐ Yes ☐ No
7. Provider attests Zavzpret® will not be used in combination with other CGRP agents: ☐ Yes ☐ No

Limitations:

- Maximum daily dose: 1 spray daily
- Maximum monthly limit: 1 box (6) per month

Initial authorization will be issued for 1 year.

☐ CONTINUATION OF THERAPY

1. Member has experienced a positive response to therapy: ☐ Yes ☐ No
2. Member is currently using a prophylactic medication unless contraindicated, not tolerated, or ineffective: ☐ Yes ☐ No

   Action required – Please indicate the current prophylactic therapy: _____
3. Provider attests Zavzpret® is being used for acute treatment of migraine and not for preventative treatment of migraine: ☐ Yes ☐ No
4. Provider attests Zavzpret® will not be used in combination with other CGRP agents: ☐ Yes ☐ No

Reauthorization will be issued for 1 year.

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

10/2023