**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**NURTEC (Rimegepant Sulfate), REYVOW (Lasmiditan Succinate) Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**
**Length of Authorizations: Initial- 4 months; Continuation- 12 months**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage **NURTEC (Rimegepant Sulfate), REYVOW (Lasmiditan Succinate).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

**KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

**1 – Patient Information**

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

**2 – Prescriber Information**

Is the prescriber a Neurologist or Pain Management Specialist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

**3 – Pharmacy Information**

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, start date: _____

2. Indicate the Member's diagnosis for the requested medication: _____

**Clinical Criteria:**

**Treatment of acute migraine*:**

1. Member has documented trial (≥ 2 months) with treatment failure, or inadequate response, to at least 3 generic oral triptan agents at maximally tolerated doses,
   □ No □ Yes

2. **AND** member has failed or has contraindication to Ubrelvy (ubrogepant)
   □ No □ Yes

**Prevention of episodic migraine (Nurtec ONLY):**

1. Patient has ≥4 and <15 migraine headache days per month (prior to initiating a migraine-preventative medication),
   □ No □ Yes

2. **AND** has documented trial (≥2 months) with treatment failure, inadequate response, or contraindication to use to at least 3 preventative agents for migraine, **2 of which must include**:
   a. Tricyclic antidepressants (e.g., amitriptyline, nortriptyline)
   b. Beta-blocker (e.g., metoprolol, propranolol)
   c. Topiramate
   d. Valproate
   □ No □ Yes

3. **AND** trial of 2 injectable CGRP antagonists (Ajovy preferred, then Emgality, then Aimovig),
   □ No □ Yes

4. **AND** trial of Qulipta (atogepant)
   □ No □ Yes

**Additional Criteria for Nurtec:**

1. If the member is on opioids or barbiturates, use is ≤ 4 days in the month prior to initiation,
   □ No □ Yes

2. **AND** member does not have BMI <18 or >40
   □ No □ Yes

**For Continuation of Therapy, Please Respond to Additional Questions Below:**

1. Member meets all the initial criteria for coverage**,**
   □ No □ Yes

2. **AND** after 3 months of treatment member has evidence of positive clinical response
   □ No □ Yes

Notes:
*Limit quantity of Nurtec to 8 tablets per 30 days when used for the treatment of acute migraine
**For either indication, patient should not use in combination with another CGRP antagonist Ajovy (fremanezumab-vfrm), Emgality (galcanezumab-gnlm), Aimovig (ernumab-aooe) or Vyepti (eptinezumab). CGRP inhibitors for migraine prevention have not been studied for use in combination with another agent in the same class. The clinical trial of Nurtec ODT for the preventive treatment of episodic migraine did not permit the use of a concomitant medication that acts on the CGRP pathway.

## 6 – Prescriber Sign-Off

**Additional Information –**

**1. Please submit chart notes/medical records for the patient that are applicable to this request.**

**2. If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

| **Prescriber Signature:** | **Date:** |
|---|---|
| | |