AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Migraine Treatment: Non-injectable drugs

Drug Requested: (Select drug below)

PREFERRED	
❑ **Nurtec® ODT** (rimegepant)	❑ **Qulipta™** (atogepant)
NON-PREFERRED	
❑ **Reyvow®** (lasmiditan) *Member must have tried and failed preferred Nurtec® ODT and meet all PA criteria	❑ **Ubrelvy™** (ubrogepant) *Member must have tried and failed preferred Nurtec® ODT and meet all PA criteria
❑ **Zavzpret™** (zavegepant) 10 mg nasal spray *Member must have tried and failed preferred Nurtec® ODT and meet all PA criteria	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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- Will the member be discontinuing a previously prescribed non-injectable calcitonin gene-related peptide (CGRP) antagonist medication if approved for requested medication?

  ❑ Yes **OR** ❑ No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

Recommended Dosing:

Drug	Dose	Quantity Limit
Nurtec® ODT	• Acute Migraine: 75 mg orally as a single dose; Maximum: 75 mg/24 hours • Preventive Migraine (Episodic): 75 mg orally every other day • The safety of treating > 18 doses in a 30-day period has not been established	• Acute Migraine: 8 tablets per 30 days • Preventive Migraine: 16 tablets per 30 days
Ubrelvy®	• Acute Migraine: Initial: 50 to 100 mg as a single dose; May repeat once based on response and tolerability after ≥ 2 hours • Maximum dose: 200 mg per 24 hours • The safety of treating > 8 migraines/month has not been established	• 10 tablets per 30 days
Reyvow®	• Acute Migraine: Initial: 50 to 100 mg as a single dose; maximum of 1 dose in 24 hours • The safety of treating > 4 migraines/month has not been established	• 4 tablets per 30 days
Qulipta®	• Preventive Migraine (Chronic & Episodic): 10 mg, 30 mg or 60 mg orally once daily • Maximum dose: 60 mg/day	• 30 tablets per 30 days
Zavzpret™	• Acute Migraine: 10 mg given as a single spray in one nostril, as needed; Maximum: 10 mg/24 hours • The safety of treating more than 8 migraines in a 30-day period has not been established	• 1 carton (6 sprays) per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization Criteria:

- ❑ Member must be 18 years of age or older
- ❑ Provider has attested to all clinical criteria for **ONE** of the applicable diagnoses below

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❑ Diagnosis: Acute Migraine

- ❑ Member must meet **ONE** of the following:
  - ❑ Member has failed (defined as ≥ 2 attacks) at least **TWO** triptans (such as sumatriptan, rizatriptan) supported by the American Headache Society/American Academy of Neurology treatment guidelines, taken at maximum recommended doses
  - ❑ Provider attests member has an intolerance to triptan therapy
  - ❑ Member has at least **ONE** of the following cardiovascular or non-cardiovascular contraindications to triptan therapy:
    - ❑ Ischemic coronary artery disease (CAD) including angina pectoris, history of myocardial infarction, documented silent ischemia, coronary artery vasospasm (including Prinzmetal's angina)
    - ❑ History of stroke or transient ischemic attack (TIA)
    - ❑ Peripheral vascular disease
    - ❑ Ischemic bowel disease
    - ❑ Uncontrolled hypertension
- ❑ For Reyvow®, Ubrelvy® and Zavzpret™ requests: Member must have trial and failure of Nurtec® ODT **(verified through pharmacy paid claims or chart notes)**
- ❑ For Nurtec® ODT or Ubrelvy® provider must attest to **ALL** the following:
  - ❑ Member does **NOT** have a CrCl < 15 mL/minute
  - ❑ Member is **NOT** currently using a strong CYP3A4 inhibitor (such as ketoconazole, itraconazole, or clarithromycin) or a strong CYP3A inducer (such as phenobarbital, phenytoin, or rifampin)
  - ❑ Member does **NOT** have severe hepatic impairment (Child-Pugh C)
- ❑ For Reyvow® requests: provider attests member has agreed to **NOT** drive or operate machinery until at least 8 hours after taking each dose
- ❑ Requested medication will **NOT** be used in combination with another oral CGRP inhibitor

❑ Diagnosis: Preventive Migraine (Applies to Nurtec® ODT and Qulipta® only)

- ❑ Member must have a diagnosis of Chronic or Episodic Migraine Headache defined by **BOTH** of the following:
  - ❑ Member has ≥ 4 migraine headaches per month
  - ❑ Member must have failed a **2-month** trial of at least one medication from **TWO** different migraine prophylactic classes supported by the American Headache Society/American Academy of Neurology treatment guidelines 2012/2015/2021/2024, Level A and B evidence; ICSI 2013, high quality evidence:
    - ❑ Anticonvulsants (divalproex, valproate, topiramate)
    - ❑ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
    - ❑ Antidepressants (amitriptyline, venlafaxine)
    - ❑ Angiotensin II Receptor Blocker (candesartan) ***requires prior authorization***
    - ❑ CGRP inhibitors (Aimovig®, Emgality®, Ajovy®, Vyepti®)

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- ❑ Provider must attest to **ALL** the following:
  - ❑ Member does **NOT** have a CrCl < 15 mL/minute for Nurtec® ODT
  - ❑ Member is **NOT** currently using a strong CYP3A4 inhibitor (such as ketoconazole, itraconazole, or clarithromycin) or a strong CYP3A inducer (such as phenobarbital, phenytoin, or rifampin)
  - ❑ Member does **NOT** have severe hepatic impairment (Child-Pugh C)
  - ❑ Requested medication will **NOT** be used in combination with another oral CGRP inhibitor
  - ❑ Nurtec® ODT and Qulipta® will **NOT** be used in combination with Aimovig®, Emgality®, Ajovy® or Vyepti®
- ❑ **Requests for concurrent use of Calcitonin Gene-Related Peptide (CGRP) inhibitors with Botox® (onabotulinumtoxinA) for migraine headache prevention (if applicable):** Member must meet **ALL** the following criteria **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ Member must have a diagnosis of Chronic or Episodic Migraine Headache and is continuing to experience ≥ 4 migraine headache days per month after receiving therapy with **ALL** the following criteria:
    - ❑ Member must have failed a **2-month** trial of at least one medication from **TWO** different migraine prophylactic classes supported by the American Headache Society/American Academy of Neurology treatment guidelines 2012/2015/2021/2024, Level A and B evidence: ICSI 2013, high quality evidence:
      - ❑ Anticonvulsants (divalproex, valproate, topiramate)
      - ❑ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
      - ❑ Antidepressants (amitriptyline, venlafaxine)
      - ❑ Angiotensin II receptor blocker (candesartan) ***requires prior authorization***
    - ❑ Member must meet **ONE** of the following:
      - ❑ Member has had an inadequate response to a **2-month** trial with an injectable CGRP inhibitor (e.g., Aimovig®, Ajovy®, Emgality®) or an oral CGRP inhibitor indicated for migraine prevention (e.g., Nurtec® ODT, Qulipta™) ***requires prior authorization***
      - ❑ Member has had an inadequate response to a **6-month** trial (2 injection cycles) of Botox® (onabotulinumtoxinA) ***requires prior authorization***

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~2/20/2020; 8/17/2023;~~ ~~9/21/2023;~~ **11/21/2024**
REVISED/UPDATED/REFORMATTED: ~~6/12/2020; 8/31/2020; 7/12/2021; 11/8/2021; 11/22/2021; 1/14/2022; 2/23/2022; 3/23/2022; 4/26/2022; 6/14/2022; 6/17/2022; 3/2/2023; 9/21/2023; 10/30/2023; 5/22/2024; 7/01/2024;~~ **12/11/2024**