Prescriber Criteria Form

Nurtec ODT 2025 PA Fax 4556-A v1 010125.docx
Nurtec ODT (rimegepant)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Nurtec ODT (rimegepant).

Drug Name:
Nurtec ODT (rimegepant)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the acute treatment of migraine with or without aura? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one triptan 5-HT1 receptor agonist? [No further questions.]	Yes ◯	No ◯
3	Is the requested drug being prescribed for the preventive treatment of episodic migraine? [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient received at least 3 months of preventive treatment with the requested drug? [If no, then skip to question 6.]	Yes ◯	No ◯
5	Has the patient had a reduction in migraine days per month from baseline? [No further questions.]	Yes ◯	No ◯
6	Has the patient experienced an inadequate treatment response with a 4-week trial of any one of the following: A) antiepileptic drugs (AEDs), B) beta-adrenergic blocking agents, C) antidepressants? [If yes, then no further questions.]	Yes ◯	No ◯

7	Has the patient experienced an intolerance or does the patient have a contraindication that would prohibit a 4-week trial of any one of the following: A) antiepileptic drugs (AEDs), B) beta-adrenergic blocking agents, C) antidepressants?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ Date:_____