Prescriber Criteria Form

Qulipta 2025 PA Fax 5001-A v2 020125.docx
Qulipta (atogepant)
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 Qulipta (atogepant).

Drug Name:
Qulipta (atogepant)

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 preventive treatment of migraine? [If no, then no further questions.]	Yes ◯	No ◯
2	Has the patient received at least 3 months of treatment with the requested drug? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient had a reduction in migraine days per month from baseline?	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:**_____