| Prescriber Criteria Form<br><br>Nurtec ODT 2024 PA Fax 4556-A v1 010124.docx<br>Nurtec ODT (rimegepant)<br>Coverage Determination |
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| This fax machine is located in a secure location as required by HIPAA regulations.<br>Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.<br>Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.<br>When conditions are met, we will authorize the coverage of Nurtec ODT (rimegepant). |

| Drug Name:<br>Nurtec ODT (rimegepant) |
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| **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.** | | | |
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| 1 | Is the requested drug being prescribed for the acute treatment of migraine with or without aura?<br>[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?<br>[No further questions.] | Yes | No |
| 3 | Is the requested drug being prescribed for the preventive treatment of episodic migraine?<br>[If no, then no further questions.] | Yes | No |
| 4 | Has the patient received at least 3 months of preventive treatment with the requested drug?<br>[If no, then skip to question 6.] | Yes | No |
| 5 | Has the patient had a reduction in migraine days per month from baseline?<br>[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?<br>[If yes, then no further questions.] | Yes | No |

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| 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 |

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| 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:_____**