



2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Nurtec

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields: Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, Specialty/facility name (if applicable).

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields: Drug Name, Strength, Directions / SIG.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a renewal request? If no, go to Q10.

Yes checkbox

No checkbox

Q2. Is the patient prescribed a dose and frequency that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes checkbox

No checkbox

Q3. Does the patient have a history of contraindication to the prescribed medication?

Yes checkbox

No checkbox

Q4. Is the requested medication being used for the acute treatment of migraine or for the preventive treatment of migraine?

Acute treatment of migraine checkbox

Preventive treatment of migraine checkbox

Q5. For acute treatment, is documentation attached showing improvement in headache pain, symptoms, or duration?



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. For acute treatment of migraine, does the quantity exceeds the quantity limit in place?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. For a quantity exceeding the quantity limit in place, does the request meet ALL of the following: a. All criteria guidelines are met b. The drug is being prescribed by a neurologist or headache specialist who is certified in headache medicine by the UCNS c. ONE of the following: i. The beneficiary is using the requested medication in addition to at least one medication for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody) ii. The beneficiary has a history of therapeutic failure, contraindication, or intolerance to all preventive migraine medications recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society) If YES, approve x 12 months. If NO, refer to Medical Director. d. Documentation of an evaluation for the overuse of abortive medications, including opioids.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. For preventive treatment of migraine, is the medication being prescribed by or in consultation with one of the following: a. A neurologist b. A headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS).	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Has the patient experienced ONE of the following: a. Has a reduction in the average number of migraine days or headache days per month from baseline b. Experienced a decrease in severity or duration of migraines from baseline	
<input type="checkbox"/> Yes	<input type="checkbox"/> No



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Patient Name:	Prescriber Name:
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Q10. Is the requested drug being prescribed for the treatment of a diagnosis that is indicated in the Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication?

Yes

No

Q11. Is the requested drug age-appropriate for the patient according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q12. Is the patient prescribed a dose and frequency that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q13. Does the patient have a history of contraindication to the prescribed medication?

Yes

No

Q14. Is the requested medication being used for the acute treatment of migraine or for the preventive treatment of migraine?

Acute treatment of migraine

Preventive treatment of migraine

Q15. For the acute treatment of migraine, does the patient have a diagnosis confirmed according to the current International Headache Society Classification of Headache Disorders?

Yes

No

Q16. 7. For the acute treatment of migraine, does the patient have BOTH of the following:

a. ONE of the following:

i. A history of therapeutic failure of at least two (5-HT 1B/1D) receptor agonists (triptans) OR

ii. Has a contraindication or intolerance to the preferred triptans

b. If currently using a different gepant, ONE of the following:

i. Will discontinue use of that gepant prior to starting the requested gepant

ii. Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. For acute treatment of migraine, does the quantity exceeds the quantity limit in place?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. For a quantity exceeding the quantity limit in place, does the request meet ALL of the following: a. All criteria guidelines are met b. The drug is being prescribed by a neurologist or headache specialist who is certified in headache medicine by the UCNS c. ONE of the following: i. The beneficiary is using the requested medication in addition to at least one medication for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody) ii. The beneficiary has a history of therapeutic failure, contraindication, or intolerance to all preventive migraine medications recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society) d. Documentation of an evaluation for the overuse of abortive medications, including opioids.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. For preventive treatment of migraine, if the medication being prescribed by or in consultation with one of the following: a. A neurologist b. A headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS).	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Is documentation attached showing baseline average number of migraine days and headache days per month?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q21. Has the patient averaged four or more migraine days per month over the previous three months?	

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Yes

No

Q22. Does the patient have a diagnosis of migraine with or without aura confirmed according to the current International Headache Society Classification of Headache Disorders?

Yes

No

Q23. Does the patient have a history of therapeutic failure, contraindication, or intolerance of at least one preventive medication from two of the following three classes:

- a. Beta-blockers (e.g., metoprolol, propranolol, timolol),
b. Antidepressants (e.g., amitriptyline, venlafaxine),
c. Anticonvulsants (e.g., topiramate, valproic acid, divalproex)

Yes

No

Q24. If currently using a different gepant, ONE of the following:

- a. Will discontinue use of that gepant prior to starting the requested gepant
b. Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines.

Yes

No

Q25. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for the beneficiary's indication?

Yes

No

Q26. Additional Information:

Prescriber Signature

Date

2024 Prior Authorization Request