Jefferson Health Plans

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**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.

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 ☐ No

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 ☐ No

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

☐ Yes ☐ No

Q4. 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

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

Jefferson Health Plans

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.

Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q6. For acute treatment of migraine, does the quantity exceeds the quantity limit in place?

☐ Yes ☐ 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.

☐ Yes ☐ 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).

☐ Yes ☐ 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

☐ Yes ☐ No

Jefferson Health Plans

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.

Patient Name:	**Prescriber Name:**

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

Jefferson Health Plans

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.

Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q17. For acute treatment of migraine, does the quantity exceeds the quantity limit in place?

☐ Yes ☐ 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.

☐ Yes ☐ 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).

☐ Yes ☐ No

Q20. Is documentation attached showing baseline average number of migraine days and headache days per month?

☐ Yes ☐ No

Q21. Has the patient averaged four or more migraine days per month over the previous three months?

Jefferson Health Plans

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.

Patient Name:	**Prescriber Name:**

☐ 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

v2025