Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

CGRP Antagonists, Acute - Ubrelvy (Ubrogepant) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Ubrelvy (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
UBRELVY 100 MG TABLET	UBRELVY 50 MG TABLET

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 90 days.
   If the answer to this question is no, go to question 2.

2. Is the medication being prescribed by, or in consultation with, a neurologist, pain specialist or headache specialist; or has the patient been seen in the emergency room for treatment of migraine; or has the patient had imaging tests for migraine? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Is the patient greater than or equal to 18 years of age? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have a diagnosis of migraine headache in the last 730 days? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, denied.

5. Does the patient have an approved prior authorization for rimegepant or ubrogepant in the last 365 days? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, go to question 6.

6. Has the patient tried and failed therapy with at least 2 different triptans, or does the patient have a contraindication to triptan therapy? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, denied.

7. Does the patient have a diagnosis of end stage renal disease (ESRD) in the last 365 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 8.

8. Does the patient have a claim for a strong CYP3A4 inhibitor or inducer in the last 30 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 9.

9. Is the requested quantity greater than 20 tablets in 30 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 10.

10. Is this request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, approved for 90 days.

11. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
    If the answer to this question is yes, approved for 90 days.
    If the answer to this question is no, go to question 12.

12. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    If the answer to this question is yes, approved for 90 days.
    If the answer to this question is no, go to question 13.

13. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer to this question is yes, approved for 90 days.
    If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date