Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Migraine Calcitonin Agents - Acute Treatment: Ubrelvy and Nurtec

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

For initial and reauthorization requests, please answer questions 1-6:

1. Is the member 18 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of migraine, with or without aura? ☐ **Yes** ☐ **No**
3. Does the member have a headache frequency of 15 or more headache days per month over the past 6 months? ☐ **Yes** ☐ **No**
4. Will the member use Ubrelvy/Nurtec concurrently with a strong CYP3A4 inhibitor? ☐ **Yes** ☐ **No**
5. Does the member have end-stage renal disease with a creatinine clearance (CrCl) less than 15ml/min? ☐ **Yes** ☐ **No**
6. Has the member tried and failed, or have a contraindication to 2 or more preferred Triptans ☐ **Yes** ☐ **No**

For reauthorization, please answer questions 1-9:

7. The member must continue to meet the above criteria. Have questions 1-6 been answered? ☐ **Yes** ☐ **No**
8. Does the member demonstrate resolution in headache pain or reduction in headache severity, as assessed by prescriber? ☐ **Yes** ☐ **No**
9. Has the member experienced any treatment-restricting adverse effects (e.g.: nausea, somnolence, dry mouth)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277