## **Trillium Health Resources Pharmacy Prior Approval Request for**



## **Migraine Calcitonin Agents - Acute Treatment: Ubrelvy and Nurtec**

Member	Information
WICHINCI	mormation

1. Last Name:			2. First Nam	ne:					
3. Trillium ID #:		2. First Name: 4. Date of Birth:			5. Gender:				
Prescriber Information									
1. Prescriber Name:		2. NPI #:							
3. Requestor Name (	Nurse/Offi	ce Staff):							
4. Mailing Address:	-		City:		State:	Zip:			
5. Phone #:		Ext	Fax #						
Drug Information									
1. Drug Name:		2. Strength:		3. Quantity Per 30 Days:					
		up to 30 Days 🛛 60 Days							
Clinical Information									
<ol> <li>Is the member 18 y</li> <li>Does the member</li> <li>Does the member</li> <li>Does the member</li> <li>Yes □ No</li> <li>Will the member us</li> <li>Does the member</li> <li>Yes □ No</li> <li>Has the member must</li> <li>Does the member</li> <li>Prescriber? □ Yes</li> <li>Has the member e</li> </ol>	vears of ag nave a dia nave a hea se Ubrelvy, nave end-s ded and fai lease ans continue to demonstra <b>D No</b>	equests, please answer questive or older? gnosis of migraine, with or with a dache frequency of 15 or more a dache frequency of 15 or more a contraindication of the strong of the str	out aura? headache o ng CYP3A4 tinine clearar to 2 or more questions 1 or reduction	lays per mon inhibitor? □ nce (CrCl) les preferred Tri -6 been answ in headache	Yes □ No s than 15ml/min ptans □ Yes □ N vered? □ Yes □ severity, as asse	? <b>No</b> essed by			
□ Yes □ No									
Signature of Prescribe	r:			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.