



Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Ubrelvy (ubrogepant)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____
Prescriber Address: _____
Prescriber Phone #: _____ Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____
Pharmacy Phone # _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____
Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
 Initial therapy Continuing therapy, state start date: _____

2. Indicate the patient’s diagnosis for the requested medication: _____

Clinical Criteria:

1. Prescriber is a Neurologist and/or pain management specialist with expertise in diagnosis/treating headache,
2. **AND** patient is ≥ 18 years or ≤ 75 years,
 No Yes
3. **AND** use is for treatment of migraine
 No Yes
4. **AND** documented trial (≥ 2 months) with treatment failure, or inadequate response, to at least 3 generic oral triptan agents at maximally tolerated doses

For continuation of therapy, please respond to additional questions below:

1. Patient meets all the initial criteria for coverage,
 No Yes
2. **AND** after 3 months of treatment, patient has positive clinical response
 No Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	Date:
------------------------------	--------------

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility