



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,
 No Yes

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
 No Yes

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:

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