



Qulipta (atogepant) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL		IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Preventive treatment of episodic migraine in adults <input type="checkbox"/> Chronic migraine <input type="checkbox"/> Other diagnosis: _____ ICD-10: _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Clinical Information: Is the patient part of a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a minimum of 4 migraine days per month, as documented by submitted chart notes? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescriber a neurologist or a physician who is board-certified in pain management (and/or has UCNS accreditation in Headache Medicine)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient previously tried at least 2 of the following migraine preventive treatment categories: (submitted chart documentation required)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Antidepressants (e.g., amitriptyline, venlafaxine, etc.), <input type="checkbox"/> Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol, etc.), <input type="checkbox"/> Anti-epileptics (e.g., valproate, topiramate, etc.), <input type="checkbox"/> Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan, etc.) Has the patient been evaluated for overuse headache due to triptans, ergot derivatives, opioid analgesics, non-opioid analgesics and combination products? <input type="checkbox"/> Yes <input type="checkbox"/> No If Renewal: Does the patient continue to meet initial criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient experiencing symptom improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient experiencing any treatment-limiting adverse reactions of the medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? <hr/> <hr/>		
Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.		





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ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

