carolina complete health

Pharmacy Prior Approval Request for Migraine Calcitonin Gene Related Therapy

Beneficiary Information

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

Prescriber Information

7. Prescribing Provider NPI #: _____
8. Requester Contact Information
   Name:_____ Phone #:_____ Ext. _____

Drug Information

9. Drug Name: _____ 10. Strength:_____ 11. Quantity Per 30 Days: _____
12. Length of Therapy: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ Other: _____

Clinical Information

Initial Request

1. Does the beneficiary have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? ☐ Yes ☐ No
2. Is the beneficiary 18 years old or older? ☐ Yes ☐ No
3. Does the beneficiary have medication over-use headache (MOH)? ☐ Yes ☐ No
4. If the beneficiary is a woman of childbearing age, has she had a negative pregnancy test at baseline? ☐ Yes ☐ No
5. Has the beneficiary experienced 4 or more migraine days per month for at least 3 months? ☐ Yes ☐ No
6. Is the beneficiary utilizing prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)? ☐ Yes ☐ No
7. Has the beneficiary tried and failed at least a month or greater trial of medications from at least 2 different classes from the following list of oral medications? ☐ Yes ☐ No
   Please list medications tried_____
   a. Antidepressants (e.g. amitriptyline, venlafaxine)
   b. Beta Blockers (e.g. propranolol, metoprolol, timolol, atenolol)
   c. Anti-epileptics (e.g. valproate, topiramate)
   d. Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g. lisinopril, candesartan)
   e. Calcium Channel Blockers (e.g. verapamil, nimodipine)

Continuation Request

1. Has the beneficiary demonstrated significant decrease in the number, frequency, and/or intensity of headaches? ☐ Yes ☐ No
2. Has the beneficiary experienced an overall improvement in function with therapy? ☐ Yes ☐ No
3. Has the beneficiary continued to utilize prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)? ☐ Yes ☐ No
4. If the beneficiary is a women of childbearing age, is she continuing to be monitored for pregnancy status? ☐ Yes ☐ No
5. Is the beneficiary experiencing unacceptable toxicity (e.g. intolerable injection site pain, constipation)? ☐ 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: (877) 386-4695

Pharmacy PA Call Center: (833) 585-4309