carolina complete health

Pharmacy Prior Approval Request for
Migraine Calcitonin Agents: Aimovig/Ajovy/Emgality/Vyepti

Beneficiary Information

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

Prescriber Information

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

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. Is the beneficiary 18 years old or older? ☐ **Yes** ☐ **No**
2. Is the beneficiary a woman of childbearing age? ☐ **Yes** ☐ **No**
   2b. Has the beneficiary had a negative pregnancy test at baseline? ☐ **Yes** ☐ **No**
3. Does the beneficiary have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? ☐ **Yes** ☐ **No**
4. Does the beneficiary have a diagnosis of episodic cluster headache? ☐ **Yes** ☐ **No**
5. For non-preferred medications, has the beneficiary tried and failed 2 preferred medications in this class? ☐ **Yes** ☐ **No**
   5b. Please list t/f medications or contraindications to the preferred medications: _____

Initial authorization for treatment of Migraines (Please answer questions 1-10) **Initial requests can be approved for up to 3-months for Aimovig, Emgality, Ajovy and Vyepti for monthly dosing or up to 6 months for Ajovy quarterly dosing**:**

6. Does the beneficiary have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? ☐ **Yes** ☐ **No**
7. Does the beneficiary have medication over-use headache (MOH)? ☐ **Yes** ☐ **No**
8. Has the beneficiary experienced 4 or more migraine days per month for at least 3 months? Yes ☐ No ☐
9. Is the beneficiary utilizing prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)? ☐ **Yes** ☐ **No**
10. 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: 1. Antidepressants (e.g. amitriptyline, venlafaxine) 2. Beta Blockers (e.g. propranolol, metoprolol, timolol, atenolol) 3. Anti-epileptics (e.g. valproate, topiramate) 4. Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g. lisinopril, candesartan) 5. Calcium Channel Blockers (e.g. verapamil, nimodipine)? ☐ **Yes** ☐ **No**
    Please list medications tried: _____

Initial authorization for treatment of Episodic Cluster Headache in Adults (Emgality 100mg/ml)(please answer questions 1-4 and 11-13) **Initial requests can be approved for up to 3-months**:**

11. Has the beneficiary experienced 2 cluster periods lasting from 7 days to 1 year (when treated) and separated by pain-free remission periods of at least 3 months? ☐ **Yes** ☐ **No**
12. Is the beneficiary utilizing prophylactic intervention modalities (e.g. medication therapy)? ☐ **Yes** ☐ **No**
13. Is the beneficiary receiving no more than 300mg (administrated as three consecutive injections of 100mg each) at the onset of the cluster headache period and then monthly until the end of the cluster headache period? ☐ **Yes** ☐ **No**

For re-authorization for all diagnosis (please answer questions 1-4 and 14-17) **Re-authorization requests can be approved for up to 12 months**:

14. Has the beneficiary experienced a significant decrease in the number, frequency, and/or intensity of headaches and/or decrease in the length of the cluster period? ☐ **Yes** ☐ **No**
15. Has the beneficiary experienced an overall improvement in function with therapy? ☐ **Yes** ☐ **No**
16. Does the beneficiary continue to utilize prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)? ☐ **Yes** ☐ **No**
17. 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: (866) 399-0929 Pharmacy PA Call Center: (833) 585-4309