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CGRP Inhibitors Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.
Provider Help Desk: 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name:_____	Prescribing physician:_____
Patient ID #: _____	Physician address: _____
Patient DOB:_____	Physician phone #: _____
Date of Rx: _____	Physician fax #:_____
Patient phone #:_____	Physician specialty:_____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Nonpreferred ☐ Aimovig ☐ Ajovy ☐ Emgality	_____	_____	Specify: _____
7. Diagnosis:_____			

8. Approval criteria: Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

Prior authorization is required for CGRP Inhibitors. Payment will be considered for a FDA approved or compendia indicated diagnosis under the following conditions:

1. Patient has one of the following diagnoses:
    a. Chronic migraine, defined as:
        i. ≥ 15 headache days per month for a minimum of three months; **and**
        ii. ≥ Eight migraine headache days per month for a minimum of three months; **or**
    b. Episodic migraine, defined as:
        i. 4-14 migraine days per month for a minimum of three months; **and**
    c. Episodic cluster Headache, defined as:
        i. Occurring with a frequency between one attack every other day and eight attacks per day; **and**
        ii. With at least two cluster periods lasting seven days to one year (when untreated) and separated by pain-free remission periods of ≥ three months; **and**
        iii. Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting < three months, for at least one year); **and**
2. Patient meets the FDA approved age for submitted diagnosis; **and**
3. Patient has been evaluated for and does not have medication overuse headache; **and**

4. For episodic and chronic migraine, patient has documentation of three trials and therapy failures, of at least three months per agent, at a maximally tolerated dose with a minimum of two different migraine prophylaxis drug classes (i.e., anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]; **or**
5. For episodic cluster headache, patient has documentation of:
    a. A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30 mg per day or dexamethasone 8 mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; **and**
    b. A previous trial and therapy failure at an adequate dose of verapamil for at least three weeks (total daily dose of 480 mg-960 mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy.
6. The requested dose does not exceed the maximum FDA labeled dose for the submitted diagnosis; **and**
7. Lost, stolen, or destroyed medication replacement requests will not be authorized.

Initial requests will be approved for three months. Additional prior authorizations will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency).
The required trials may be overridden when documented evidence that use of these agents would be medically contraindicated is provided.

Chronic migraine (must document each criteria below)
Patient has ≥ 15 headache days per month for a minimum of three months
Number of headache days per month:
Month 1: _____ Month 2: _____Month 3: _____

Patient has ≥ eight migraine headache days per month for a minimum of three months
Number of migraine headache days per month:
Month 1: _____Month 2: _____Month 3: _____

Episodic migraine
Patient has 4-14 migraine headache days per month for a minimum of three months
Number of migraine headache days per month: Duration (months):
Month 1: _____Month 2: _____Month 3: _____

Chronic or episodic migraine treatment failures
Trial 1: Name/dose: _____Trial dates:_____
Failure reason: _____

Trial 2: Name/dose: _____Trial dates:_____
Failure reason: _____

Trial 3: Name/dose: _____Trial dates:_____
Failure reason: _____

Episodic cluster headache (must document each criterion below):
1. Occurs with a frequency between one attack every other day and eight attacks per day:
   Frequency: _____
2. Patient has at least two cluster periods lasting seven days to one year (when untreated) and separated by pain-free remission periods of ≥ three months:
   # of cluster periods: _____ Length of cluster periods:_____
   Does patient have pain-free remission periods? ☐ Yes ☐ No
   If yes, length of pain-free remission periods: _____
3. Does patient have chronic cluster headache? ☐ Yes ☐ No

Episodic cluster headache treatment failures:
Glucocorticoid trial: Name/dose: _____Trial dates: _____

Failure reason: _____
_____

Verapamil trial: Name/dose: _____Trial dates: _____
Failure reason: _____
_____

Has patient been evaluated and medication overuse headache ruled out? ☐ **Yes** ☐ **No**

Renewal requests:
Document clinical response to therapy: _____
_____
_____

For chronic or episodic migraine: number of headache/migraine days per month since start of therapy:
_____

For episodic cluster headache: number of cluster periods since start of therapy:
_____

Possible drug interactions/conflicting drug therapies:
_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.