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Medicaid

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Calcitonin Gene-Related Peptide Receptor (CGRP) Antagonists, Chronic Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information

Patient name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

Patient phone #: _____

Patient email address: _____

2. Physician information

Prescribing physician: _____

Physician address: _____

Physician phone #: _____

Physician fax #: _____

Physician specialty: _____

Physician DEA: _____

Physician NPI #: _____

Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
			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.)

□ Yes □ No Does the member have a diagnosis of episodic migraines (defined as having between 4 and 14 migraine days per month and less than 15 headache days per month on average in the last 90 days)?

□ Yes □ No Does the client have a diagnosis of chronic migraines (defined as having greater than or equal to (≥) 8 migraine days per month and greater than or equal to (≥) 15) headache days per month on average in the last 90 days)?

□ Yes □ No Does the client have a diagnosis of episodic cluster headaches (defined as having two cluster periods lasting from 7 days to one year and separated by pain-free remission periods of greater than or equal to (≥) 3 months)?

□ Yes □ No Does the client have a diagnosis of severe hepatic impairment in the last 365 days?

□ Yes □ No Does the client have a diagnosis of severe renal impairment or end-stage renal disease (ESRD) in the last 365 days?

□ Yes □ No Will the client have concurrent therapy with another CGRP Antagonist for prophylaxis of migraines?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**

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.