AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Migraine Calcitonin Agents: Preventative (Aimovig, Ajovy, Emgality, Nurtec, Qulipta, Vyepti)

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days

Clinical Information

Initial authorization FOR ALL DIAGNOSES:

1. Is the beneficiary 18 years old or older? Yes___ No___
2. Is the beneficiary utilizing prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, lifestyle modifications for preventative treatment of migraines, or medication therapy for episodic cluster headaches)? Yes___ No___

Initial authorization for PREVENTATIVE treatment of Migraines – INJECTABLES and ORALS:

1. Does the beneficiary have a diagnosis of migraine with or without aura based on the International Classification of Headache Disorders criteria? Yes___ No___
2. Does the beneficiary have medication overuse headache (MOH)? Yes___ No___
3. Has the beneficiary experienced 4 or more migraine days per month for at least 3 months? Yes___ No___

Initial authorization for PREVENTATIVE treatment of Migraines (INJECTABLES) (Aimovig, Ajovy, Emgality 120mg/ml, and Vyepti):

1. For beneficiaries that are women of childbearing age, is there a negative pregnancy test at baseline? Yes___ No___
2. 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 PREVENTATIVE treatment of Migraines (ORALS) (Nurtec ODT, Qulipta):

1. Has the beneficiary tried and failed at least 2 preferred injectable CGRPs? Yes___ No___
2. **For Nurtec ONLY**
   2a. Will the Beneficiary use Nurtec concurrently with a strong CYP3A4 inhibitor? Yes___ No___
   2b. Does the Beneficiary have end-stage renal disease with a creatinine clearance (CrCl) less than 15ml/min? Yes___ No___

Initial authorization for treatment of Episodic Cluster Headache in Adults (Emgality 100mg/ml):

1. Does the beneficiary have a diagnosis of Episodic Cluster Headache? Yes___ No___
2. Has the beneficiary experienced 2 cluster periods lasting from 7 days to 1 year (when untreated) and separated by pain-free remission periods of at least 3 months? Yes__ No___
3. For beneficiaries that are women of childbearing age, is there a negative pregnancy test at baseline? Yes___ No___

For re-authorization for all diagnoses:

1. 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___
2. Has the beneficiary experienced an overall improvement in function with therapy? Yes___ No___
3. Does the beneficiary continue to utilize prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, lifestyle modifications, medications)? Yes___ No___
4. If the beneficiary is a woman of childbearing age, is the provider continuing to monitor for pregnancy status? Yes___ No___

(not required for Nurtec or Qulipta)

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406