# MIGRAINE PREVENTION AGENTS
(form effective 1/3/2022)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

## PRIOR AUTHORIZATION REQUEST INFORMATION

| | | |
|---|---|---|
| ☐ New request ☐ Renewal request | # of pages: | Name of office contact: |
| Contact's phone number: | | LTC facility contact/phone: |

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Patient name: | | Patient ID #: | | DOB: |
| Street address: | Apt. #: | | City/state/zip: | |

## PRESCRIBER INFORMATION

| | | | |
|---|---|---|---|
| Prescriber name: | | Specialty: | |
| State license #: | NPI: | | MA Provider ID#: |
| Street address: | Suite #: | | City/state/zip: |
| Phone: | | Fax: | |

## PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

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|---|---|
| Pharmacy Phone #: | Pharmacy Fax #: |

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

## CLINICAL INFORMATION

Product requested (clinical prior auth required):

☐ Aimovig 70 mg/ml autoinjector (1 autoinjector/package)
☐ Aimovig 140 mg/ml autoinjector (1autoinjector/package)
☐ Aimovig 140 mg dose (2 x 70 mg autoinjectors/package)
☐ Ajovy 225 mg/1.5 ml syringe
☐ Ajovy 225 mg/1.5 ml autoinjector
☐ Emgality 120 mg/ml autoinjector
☐ Emgality 120 mg/ml syringe
☐ Emgality 300 mg (100 mg/ml syringe x 3)
☐ Nurtec ODT 75 mg
☐ Vyepti IV Solution 100 mg/ml
☐ _____
☐ _____

| | | |
|---|---|---|
| Dose/directions | Quantity: | Refills: |
| Diagnosis (submit documentation): | DX code (required): | |

Is the medication being prescribed by, or in consultation with, a neurologist or headache specialist? ☐ Yes *Submit documentation of consultation, if applicable.* ☐ No

## ALL INITIAL REQUESTS

1. If the patient is currently using a Migraine Prevention Agent, one of the following:
   ☐ Will discontinue use of that Migraine Prevention Agent prior to starting the requested Migraine Prevention Agent
   ☐ Has a medical reason for concomitant use of both Migraine Prevention Agents that is supported by peer-reviewed literature or national treatment guidelines. Please explain:

2. For a gepant (such as Nurtec ODT), if currently using a different gepant (such as Ubrelvy), one of the following:
   ☐ Will discontinue use of that gepant prior to starting the requested gepant
   ☐ Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines. Please explain:

3. For a non-preferred agent: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication?
   ☐ Yes ☐ No

   If yes, select medications tried.
   ☐ Aimovig ☐ Emgality ☐ Nurtec ODT ☐ Other:

## INITIAL REQUESTS FOR MIGRAINES

1. Has the patient averaged 4 or more migraine days per month over the past 3 months? ☐ Yes ☐ No

2. For Nurtec ODT: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication?
   ☐ Yes ☐ No

   If yes, select medications tried.
   ☐ Aimovig ☐ Emgality ☐ Other:

3. Does the patient have a confirmed diagnosis of migraine (with or without aura) according to the current International Headache Society Classification of Headache Disorders?
   ☐ Yes ☐ No

4. Does the patient have a history of trial and failure of or contraindication or intolerance to at least one drug from two of the following three classes?
   ☐ anticonvulsants (e.g., divalproex, topiramate, valproic acid) ☐ antidepressants (e.g., amitriptyline, venlafaxine) ☐ beta blockers (e.g., metoprolol, propranolol, timolol)

   ☐ Yes - List medications tried:
   ☐ No

5. Provide average number of migraine days and headache days per month at baseline:

## INITIAL REQUESTS FOR EPISODIC CLUSTER HEADACHE

1. Does the patient have confirmed diagnosis of episodic cluster headache according to the current International Headache Society Classification of Headache Disorders?
   ☐ Yes ☐ No
2. Does the patient have a history of trial and failure, contraindication, or intolerance of a preventive medication recommended by current consensus guidelines for episodic cluster headaches?
   ☐ Yes - *List medications tried:*
   ☐ No

## RENEWAL REQUESTS

1. For the prevention of migraine: Since starting the requested medication, did the patient experience one of the following:
   ☐ Reduction in the average number of migraine days per month from baseline
   ☐ Decrease in severity or duration of migraines from baseline
2. For episodic cluster headache: Since starting the requested medication, did the patient experience a reduction in cluster headache frequency from baseline? ☐ Yes ☐ No
3. For Nurtec ODT, for the prevention of migraine: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication? ☐ Yes ☐ No
   If yes, select medications tried:
   ☐ Aimovig ☐ Emgality ☐ Other:
4. For a non-preferred agent: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication? ☐ Yes ☐ No
   If yes, select medications tried:
   ☐ Aimovig ☐ Emgality ☐ Nurtec ODT ☐ Other:

## PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

| Prescriber signature: | Date: |
|---|---|