State of Oklahoma
SoonerCare
Qulipta™ (Atogepant) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

Pharmacy billing (NDC:_____) Start Date (or date of next dose):_____

Dose: _____ Regimen:_____ Fill Quantity:_____ Day Supply:_____

Billing Provider Information

Provider NPI:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization (Initial approval will be for the duration of 3 months):

1. What is the member's diagnosis?
   - ❑ Preventative treatment of migraines in adults
   - ❑ Other, please list:_____
2. Does the member have documented:
   - ❑ Episodic Migraine Headache
   - ❑ Other, please list:_____
3. Date of member's episodic migraine diagnosis?_____
4. Number of headache days per month?_____
5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)?_____
6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated?
   a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes____ No____
   b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes____ No____
7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated?
   a. Hormone replacement therapy or hormone-based contraceptives? Yes____ No____
   b. Chronic insomnia? Yes____ No____
   c. Obstructive sleep apnea? Yes____ No____
8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes____ No____ If yes, please list:
   Medication_____ Date Span_____ Dosing_____
   Medication_____ Date Span_____ Dosing_____
   Medication_____ Date Span_____ Dosing_____
9. If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s):
   Medication(s)_____
   Reason(s) for discontinuation prior to 8 weeks: _____
10. Is the member taking any of the following medications **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain?
    a. Decongestants (alone or in combination products)? Yes____ No____
    b. Combination analgesics containing caffeine and/or butalbital? Yes____ No____
    c. Opioid-containing medications? Yes____ No____
    d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes__ No__
    e. Ergotamine-containing medications? Yes____ No____
    f. Triptans? Yes____ No____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Qulipta™ (Atogepant) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.
Page 2 of 2—Please complete and return <u>all</u> pages. *Failure to complete all pages will result in processing delays*.

For Initial Authorization (continued):

11. Is the member taking any of the medications, listed in Question 10., **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? Yes____ No____
    a. If yes, to <u>any</u> of the medication(s) listed in Question 10., please list the medication(s) and the number of days per month taken:_____
    _____
    b. If yes, to <u>any</u> of the medication(s) listed in Question 10., please provide additional information to support member's need for continued use of medication(s) known to cause overuse or rebound headaches:
    _____
    _____
12. Is the member taking any medications that are **likely** to be the cause of the headaches? Yes____ No____
13. Has the member been evaluated within the last 6 months by a neurologist for migraine headaches and was Qulipta™ recommended as treatment? Yes____ No____
    a. If yes, please include name of neurologist recommending Qulipta™ treatment_____
14. Will member use Qulipta™ concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor? Yes____ No____
15. If applicable, are other aggravating factors that contribute to the development of episodic/chronic migraine headaches being treated (e.g., smoking)? Yes____ No____ Not Applicable____
16. Please provide a patient-specific, clinically significant reason why the member cannot use Emgality® (galcanezumab-gnlm) or Ajovy® (fremanezumab-vfrm):
    _____
    _____

Additional Information:_____
_____

For Continued Authorization (Compliance and information regarding efficacy will be required for continued approval):

1. Has the member been compliant with Qulipta™ (atogepant) treatment? Yes____ No____
2. Has the member responded well to treatment with Qulipta™ (atogepant)? Yes____ No____
3. Please provide the member's current number of migraine days per month:_____

Additional Information:_____
_____

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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