

Migraine Calcitonin Agents: Aimovig/Ajovy/Emgality/Vyepti/ Qulipta/Nurtec Prior Authorization Form

Member Information			
1. Member last name:		2. Member first name:	
3. Member ID #:	4. Member date of birth:	5. Member gender:	
Prescriber Information			
6. Prescribing provider NPI#:			
7. Requester contact information			
Name:			
Phone:		Ext:	
Drug Information			
8. Drug name:		9. Strength:	
10. Quantity per 30 days:			
11. Length of therapy (in days): <input type="checkbox"/> up to 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days			
Clinical Information			
1. Is the member 18 years old or older? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Is the member a woman of childbearing age? <input type="checkbox"/> Yes <input type="checkbox"/> No (not required for Qulipta or Nurtec)			
2a. Has the member had a negative pregnancy test at baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No (not required for Qulipta or Nurtec)			
3. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Does the member have a diagnosis of episodic cluster headache? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. For non-preferred medications, has the member tried and failed 2 preferred medications in this class? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5a. Please list t/f medications or contraindications to the preferred medications:			
Initial authorization for treatment of Migraines (Please answer questions 1-10) **Initial requests can be approved for up to 3 months for Aimovig, Emgality, Ajovy, Qulipta and Vyepti for monthly dosing or up to 6 months for Ajovy quarterly dosing**:			
6. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No			
7. Does the member have medication over-use headache (MOH)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Has the member experienced 4 or more migraine days per month for at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Is the member utilizing prophylactic intervention modalities (for example, behavioral therapy, physical therapy, life-style modifications)? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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10. Has the member 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 (amitriptyline, venlafaxine) 2. Beta Blockers (propranolol, metoprolol, timolol, atenolol) 3. Anti-epileptics (valproate, topiramate) 4. Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (lisinopril, candesartan) 5. Calcium Channel Blockers (verapamil, nimodipine)? ☐ Yes ☐ No

Please list medications tried:

11. Will the Beneficiary use Ubrelvy/Nurtec concurrently with a strong CYP3A4 inhibitor? ☐ Yes ☐ No

12. 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)(please answer questions 1-4 and 13-15) **Initial requests can be approved for up to 3 months**:

13. Has the member experienced 2 cluster periods lasting from 7 days to 1 year (when treated) and separated by pain-free remission periods of at least 3 months? ☐ Yes ☐ No

14. Is the member utilizing prophylactic intervention modalities (for example, medication therapy)? ☐ Yes ☐ No

15. Is the member receiving no more than 300mg (administered as three consecutive injections of 100mg each) at the onset of the cluster headache period and then monthly until the end of the cluster headache period?
☐ Yes ☐ No

For re-authorization for all diagnosis (please answer questions 1-4 and 16-20) **Re-authorization requests can be approved for up to 12 months**:

16. Has the member 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

17. Has the member experienced an overall improvement in function with therapy? ☐ Yes ☐ No

18. Does the beneficiary continue to utilize prophylactic intervention modalities (behavioral therapy, physical therapy, life-style modifications)? ☐ Yes ☐ No

19. If the member is a woman of childbearing age, is the provider continuing to monitor for pregnancy status?
☐ Yes ☐ No **(not required for Qulipta or Nurtec)**

20. Is the member experiencing unacceptable toxicity (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 **844-376-2318**
Healthy Blue Pharmacy PA Call Center: **844-594-5072**