PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

CGRP Inhibitors: Aimovig, Ajovy, Emgality, and Vyepti

Patient/Provider Information:

Subscriber ID Number			Group Number
Patient Name	Patient Telephone Number		Date of Birth
Patient Address	City	State	Zip Code
Physician Name	Phone		Fax
Physician Address with Suite / Building	City	State	Zip Code
NPI	Physician Signature		Date

Clinical Information:

Medication Requested: _____ Dose and Quantity Requested: _____

Documentation of Medical Necessity:

1. Please select the patient's diagnosis:
   - ☐ Episodic Migraine Prophylaxis (4-14 headache days per month)
   - ☐ Chronic Migraine Prophylaxis (15 or more headache days per month, of which 8 or more are migraine days)
   - ☐ Episodic Cluster Headache (severe unilateral orbital, supraorbital, and/or temporal pain lasting 15 to 180 minutes when left untreated) → **For this diagnosis only, go to question 6**
   - ☐ Other diagnosis with ICD -10 Code: _____

2. On average, how many days per month does the patient experience a migraine prior to starting this medication?
   _____ days per month

3. Are the patient's headaches caused by medication rebound or overutilization (taking narcotics or triptans exceeding more than 18 doses per month) or lifestyle factors (e.g. sleep patterns, caffeine use, etc.)?
   ☐ Yes ☐ No

4. Has the patient experienced therapeutic failure or intolerance to any of the following?
   Please select **ALL** that apply:
   - ☐ Anti-epileptic drugs (e.g. topiramate, valproic acid, divalproex sodium, carbamazepine, etc.)
   - ☐ Beta-blockers (e.g. propranolol, timolol, metoprolol, etc.)
   - ☐ Calcium-channel blockers (e.g. verapamil, amlodipine, etc.)
   - ☐ Serotonin-norepinephrine reuptake inhibitors (e.g. venlafaxine, duloxetine, etc.)
   - ☐ Tricyclic antidepressants (e.g. amitriptyline, nortriptyline, etc.)
   - ☐ Botox (onobotulinum toxin A)
   - ☐ Alpha-agonists (e.g. clonidine, guanfacine, etc.)
   - ☐ ACE Inhibitors/Angiotensin II receptor blockers (e.g. lisinopril, candesartan, etc.)
   - ☐ Other _____

5. Will the patient use the requested medication in combination with Nurtec ODT or Ubrelvy?
   ☐ Yes ☐ No

   If **YES**:
   a. Do the benefits of therapy outweigh the risks of concurrent use of both medications?
   ☐ Yes ☐ No

6. For **episodic cluster headache only**: is the patient experiencing attack frequency of at least one attack every other day during a cluster period?
   ☐ Yes ☐ No

7. **For reauthorization requests:**

   Has the patient experienced at least a 50% reduction in the number of migraine days per month compared to the start of therapy?
   ☐ Yes ☐ No

   If the patient has a diagnosis of **episodic migraine**, has the patient experienced a reduction of **at least 4** monthly migraine days since the start of therapy?
   ☐ Yes ☐ No

   If the patient has a diagnosis of **chronic migraine**, has the patient experienced a reduction of **at least 5** monthly migraine days since the start of therapy?
   ☐ Yes ☐ No

   If the patient has a diagnosis of **episodic cluster headache**, has the patient experienced a reduction in the number of mean weekly cluster headaches from baseline?
   ☐ Yes ☐ No

8. Please provide any additional information pertinent to this request: _____
   _____
   _____

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.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **copleted** form and all clinical documentation to **1-866-240-8123**