Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
CGRP Inhibitors Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 4 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **CGRP Inhibitors .** This PA form includes **Emgality (galcanezumab-gnlm), Aimovig (erenumab-aooe), Ajovy (fremanezumab-vfrm), and Ubrelvy (ubrogepant).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a neurologist or pain management specialist with expertise in diagnosis/treating headache ? □ Yes □ No

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Diagnosis

□ Migraine
□ Cluster
□ Other: _____

6– Clinical Criteria

1. Is this request for initial or continuing therapy?

   □ Initial therapy □ Continuing therapy, State date: _____

2. Is the member's age ≥18 years or ≤ 75 years, **AND**
   □ No □ Yes
3. Prescribed for treatment of chronic migraine (defined as ≥ 15 headache days [migraine-like or tension-like] per month for the past 3 months) or episodic migraine (≥ 8 days/month or ≥ 2 disabling migraines/month lasting at least 72 hours for the past 3 months), **OR**
   □ No □ Yes
4. Does the member have a documented trial (≥2 months) with treatment failure, inadequate response, or contraindication to use to at least 3 preventative agents for migraine, 2 of which must include:
   - Tricyclic antidepressants (e.g., amitriptyline, nortriptyline)
   - Beta-blocker (e.g., metoprolol, propranolol)
   - Topiramate
   - Valproate, AND

   □ No □ Yes

5. Member must have documented treatment failure or inadequate response to a ≥2-month trial of Ajovy before being approved for Emgality, **OR**

   □ No □ Yes

6. Member must have documented treatment failure or inadequate response to a ≥2-month trial of Ajovy (preferred) and Emgality before being approved for Aimovig

   □ No □ Yes

Additional diagnoses covered for Emgality only:

7. Prescribed for the treatment of episodic cluster headache (≥ 2 cluster periods lasting from 7 days to 1 year, separated with pain-free remission periods between attacks ≥ 1 months), currently with frequency of attacks ≥1 attack every other day, **AND**

   □ No □ Yes

8. Has a history of cluster headache period lasting ≥6 weeks?

   □ No □ Yes

Additional diagnoses covered for Ubrelvy only:

9. Is Ubrelvy used is for treatment of migraine, **AND**

   □ No □ Yes

10. Has documented trial (≥2 months) with treatment failure, or inadequate response, to at least 3 generic oral triptan agents at maximally tolerated doses?

    □ No □ Yes

For continuation of therapy, please respond to additional questions below:

11. Member meets all the initial criteria for coverage, **AND**
    □ No □ Yes
12. After 3 months of treatment patient has positive clinical response

    □ No □ Yes

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**