

Request for Prior Authorization Select Preventative Migraine Treatments

(PLEASE PRINT – ACCURACY IS IMPORTANT)

- b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy.

7. Lost, stolen, or destroyed medication replacement requests will not be authorized.

Initial requests will be approved for three months. Additional prior authorizations will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency).

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

Aimovig Ajovy

Non-Preferred

Emgality Nurtec ODT Qulipta

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

Chronic Migraine (must document each criterion below):

- 1. Patient has ≥ 15 headache days per month for a minimum of 3 months
Number of headache days each month:

Month 1: _____ Month 2: _____ Month 3: _____

- 2. Patient has ≥ 8 migraine headache days per month for a minimum of 3 months
Number of migraine headache days each month:

Month 1: _____ Month 2: _____ Month 3: _____

Episodic Migraine:

- 1. Patient has 4 to 14 migraine headache days per month for a minimum of 3 months
Number of migraine headache days each month:

Month 1: _____ Month 2: _____ Month 3: _____

Chronic or Episodic Migraine treatment failures:

Trial 1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Trial 2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

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Trial 3: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Episodic Cluster Headache (must document each criterion below):

1. Occurs with a frequency between one attack every other day and 8 attacks per day:
Frequency: _____:

2. Patient has at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods of ≥ 3 months:

of cluster periods: _____ Length of cluster periods: _____

Does patient have pain-free remission periods? Yes No

If yes, length of pain-free remission periods: _____

3. Does patient have chronic cluster headache? Yes No

Episodic Cluster Headache treatment failures:

Glucocorticoid Trial: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Verapamil Trial: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Has patient been evaluated and medication overuse headache ruled out? Yes No

Is requested agent being used in combination with another CGRP inhibitor for the preventative treatment of migraine? Yes No

Requests for Non-Preferred Agents: Document trial of a select preventative migraine agent

Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Renewal Requests: Document clinical response to therapy: _____

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For chronic or episodic migraine: number of headache/migraine days per month since start of therapy:

For episodic cluster headache: number of cluster periods since start of therapy: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.