ANTIMIGRAINE AGENTS, OTHER – CGRP INHIBITORS PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774.**

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	# of pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:		Specialty:	
State license #:	NPI:		MA Provider ID#:
Street address:	Suite #:	City/state/zip:	
Phone:		Fax:	

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #:	Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

CLINICAL INFORMATION

Product requested (clinical prior auth required):

☐ Aimovig 70 mg/ml autoinjector (1 autoinjector/package)
☐ Aimovig 140 mg/ml autoinjector (1autoinjector/package)
☐ Aimovig 140 mg dose (2 x 70 mg autoinjectors/package)
☐ _____

☐ Ajovy 225 mg/1.5 ml syringe
☐ Emgality 120 mg/ml pen
☐ Emgality 120 mg/ml syringe
☐ _____

Dose/directions	Quantity:	Refills:
Diagnosis (submit documentation):	DX code (required):	

Is the medication being prescribed by, or in consultation with, a neurologist or headache specialist? ☐ Yes *Submit documentation of consultation, if applicable.* ☐ No

INITIAL REQUESTS

1. Has the patient averaged 4 or more migraine days per month over the past 3 months?
   ☐ Yes ☐ No
2. Does the patient have a confirmed diagnosis of migraine (with or without aura) according to the current International Headache Society Classification of Headache Disorders?
   ☐ Yes - *Submit documentation of diagnosis.* ☐ No
3. Does the patient have a history of trial and failure, contraindication, or intolerance of medications from the following 3 drug classes used for the prevention of migraine?
   ☐ anticonvulsants (e.g., divalproex, topiramate, valproic acid) ☐ antidepressants (e.g., amitriptyline, venlafaxine) ☐ beta blockers (e.g., metoprolol, propranolol, timolol)
   ☐ Yes - List medications tried:
   ☐ No
4. Will the patient be using botulinum toxin (e.g., Botox, Dysport, Myobloc, Xeomin) concomitantly with the requested medication?
   ☐ Yes - *Submit documentation of consultation, if applicable.* ☐ No
5. Request for a non-preferred agent: Has the patient tried and failed the preferred CGRP Inhibitor, Emgality? ☐ Yes ☐ No
6. Provide average number of migraine days and headache days per month:

RENEWAL REQUESTS

1. Since starting the requested medication, did the patient experience a reduction in the average number of headache or migraine days per month or decrease in severity and/or duration of headaches or migraines?
   ☐ Yes - S*ubmit documentation of clinical response.* ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: