MIGRAINE PREVENTION AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/6/2025)

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):

Preferred		Non-Preferred
☐ Aimovig 70 mg/ml autoinjector ☐ Aimovig 140 mg/ml autoinjector ☐ Ajovy 225 mg/1.5 ml autoinjector ☐ Ajovy 225 mg/1.5 ml syringe	☐ Emgality 120 mg/ml autoinjector ☐ Emgality 120 mg/ml syringe ☐ Emgality 300 mg (100 mg/ml syringe x 3) ☐ Nurtec ODT 75 mg	☐ Qulipta Tablet 10 mg ☐ Qulipta Tablet 30 mg ☐ Qulipta Tablet 60 mg ☐ Vyepti IV Solution 100 mg/ml ☐ Other:_____

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

Is the medication being prescribed by, or in consultation with, a neurologist or a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)? ☐ Yes *Submit documentation of consultation, if applicable.* ☐ No

ALL INITIAL REQUESTS

1. If the patient is currently using a Migraine Prevention Agent, one of the following:
   ☐ Will discontinue use of that Migraine Prevention Agent prior to starting the requested Migraine Prevention Agent
   ☐ Has a medical reason for concomitant use of both Migraine Prevention Agents that is supported by peer-reviewed literature or national treatment guidelines. Please explain:

2. For a non-preferred agent: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication?
   ☐ Yes ☐ No

   If yes, select medications tried.
   ☐ Aimovig ☐ Ajovy ☐ Emgality ☐ Nurtec ODT ☐ Other:

INITIAL REQUESTS FOR MIGRAINES

1. Has the patient averaged 4 or more migraine days per month over the past 3 months? ☐ Yes ☐ No

2. For gepant (e.g., Nurtec ODT, Qulipta): Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication?
   ☐ Yes ☐ No

   If yes, select medications tried.
   ☐ Aimovig ☐ Ajovy ☐ Emgality ☐ Other:

3. 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 ☐ No

4. Does the patient have a history of trial and failure of or contraindication or intolerance to at least one drug from one of the following three classes?
   ☐ anticonvulsants (e.g., divalproex, topiramate, valproic acid) ☐ antidepressants (e.g., amitriptyline, venlafaxine) ☐ beta blockers (e.g., metoprolol, propranolol, timolol)

   ☐ Yes - List medications tried:
   ☐ No

5. Provide average number of migraine days and headache days per month at baseline:

INITIAL REQUESTS FOR EPISODIC CLUSTER HEADACHE

1. Does the patient have confirmed diagnosis of episodic cluster headache according to the current International Headache Society Classification of Headache Disorders?
   ☐ Yes ☐ No

2. Does the patient have a history of trial and failure, contraindication, or intolerance of a preventive medication recommended by current consensus guidelines for episodic cluster headaches?
   ☐ Yes - *List medications tried:*
   ☐ No

RENEWAL REQUESTS

1. For the prevention of migraine: Since starting the requested medication, did the patient experience one of the following:
   ☐ Reduction in the average number of migraine days per month from baseline
   ☐ Decrease in severity or duration of migraines from baseline
2. For episodic cluster headache: Since starting the requested medication, did the patient experience a reduction in cluster headache frequency from baseline? ☐ Yes ☐ No
3. For gepant (e.g., Nurtec ODT, Qulipta), for the prevention of migraine: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication? ☐ Yes ☐ No
   If yes, select medications tried:
   ☐ Aimovig ☐ Ajovy ☐ Emgality ☐ Other:
4. For a non-preferred agent: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication? ☐ Yes ☐ No
   If yes, select medications tried:
   ☐ Aimovig ☐ Ajovy ☐ Emgality ☐ Nurtec ODT ☐ Other:

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: