



Antimigraine Agents, Others Prior Authorization (PA) Form

Page 2 of 7

Drug name:	_____	Drug form:	_____
Drug strength:	_____	Dosing frequency:	_____
Length of therapy:	_____	Quantity per day:	_____

*(Form continued next page.)*

Member's last name:

Member's first name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

<b>Preventive treatment of migraine</b>	
Preferred agents *step edit required	Nonpreferred agents (PA required)
Aimovig <sup>®</sup> , Ajoovy <sup>®</sup> and Ajoovy <sup>®</sup> autoinjector Emgality <sup>®</sup> pen and syringe (120 mg), Nurtec <sup>®</sup> ODT, Qulipta <sup>™</sup>	Emgality <sup>®</sup> syringe (100 mg), Vyepti <sup>®</sup>
<b>Acute treatment of migraine</b>	
Preferred agents (No PA with trial of two generic triptans)	Nonpreferred agents (PA required)
Nurtec <sup>®</sup> ODT, Ubrelvy <sup>™</sup>	Reyvow <sup>®</sup> , Zavzpret <sup>™</sup>

**Drug information (continued)**

Identify why the preferred agents cannot be used.

*(Form continued next page.)*

Member's last name:

Member's first name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Diagnosis and medical information**

**All drugs in this class are eligible to receive a six-month approval. Complete the following questions.**

**For preventive treatment of migraine, does the member meet the \*step edit and the following criteria?**

1. Has the prescriber assessed baseline disease severity utilizing an objective measure/tool (e.g., International Classification of Headache Disorders (ICHD-III); Headache Impact Test [HIT-6];

monthly headache day [MHD]; Migraine Disability Assessment [MIDAS]; Migraine Physical Function Impact Diary [MPFID])? AND

Yes  No

2. Does the member meet the FDA indicated age for the requested product? AND

Yes  No

3. Has the member had  $\geq$  four migraine days per month for at least 3 months? AND

Yes  No

4. \*Has the member tried and failed a  $\geq$  1-month trial of any 2 of the following oral generic medications?

- Antidepressants (for example, amitriptyline, venlafaxine)
- Beta blockers (for example, propranolol, metoprolol, timolol, atenolol)
- Anti-epileptics (for example, valproate, topiramate)
- Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (for example, lisinopril, candesartan)

Yes  No

5. For Nurtec and Qulipta, has the member tried and failed 1 of the preferred injectable agents?

Yes  No

**For renewal, complete the following question to receive a 12-month approval.**

1. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

Yes  No

*(Form continued next page.)*

Member's last name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member's first name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**For acute treatment of migraine, does the member meet the \*step edit and the following criteria?**

1. Does the member have a diagnosis of migraine with or without aura? AND  
 Yes  No
2. Is the member  $\geq 18$  years of age? AND  
 Yes  No
3. \*Has the member tried and failed (or has contraindications to) two preferred triptan medications?  
 Yes  No

**For renewal, complete the following question to receive a 12-month approval.**

1. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?  
 Yes  No

**For episodic cluster headache, does the member meet the following criteria?**

1. Does the member have a diagnosis of episodic cluster headache? AND  
 Yes  No
2. Is the member  $\geq 18$  years of age? AND  
 Yes  No
3. Has the member experienced at least 2 cluster periods lasting from 7 to 365 days, separated by pain-free periods lasting at least three months? AND  
 Yes  No
4. Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines? AND  
 Yes  No
5. Has the member tried and failed (or has contraindications to) at least one standard prophylactic (preventive) pharmacologic therapy for cluster headache?  
 Yes  No

**For renewal, complete the following question to receive a 12-month approval.**

1. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

Yes  No

*(Form continued next page.)*

