iowa total care | ia health link | Hawki | envolve Pharmacy Solutions

FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
CGRP Inhibitors

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for CGRP Inhibitors. Payment will be considered for a FDA approved or compendia indicated diagnosis under the following conditions:

1. **Patient has one of the following diagnoses:**
   - a. **Chronic Migraine, defined as:**
     - i. **≥ 15 headache days per month for a minimum of 3 months; and**
     - ii. **≥ 8 migraine headache days per month for a minimum of 3 months; or**
   - b. **Episodic Migraine, defined as:**
     - i. **4 to 14 migraine days per month for a minimum of 3 months; or**
   - c. **Episodic Cluster Headache, defined as:**
     - i. **Occurring with a frequency between one attack every other day and 8 attacks per day; and**
     - ii. **With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods of ≥ 3 months; and**
     - iii. **Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting < 3 months, for at least 1 year); and**
2. **Patient meets the FDA approved age for submitted diagnosis; and**
3. **Patient has been evaluated for and does not have medication overuse headache; and**
4. **For Episodic and Chronic Migraine, patient has documentation of three trials and therapy failures, of at least three months per agent, at a maximally tolerated dose with a minimum of two different migraine prophylaxis drug classes (i.e., anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]; or**
5. **For Episodic Cluster Headache, patient has documentation of:**
   - a. **A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and**
   - 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.**
6. **The requested dose does not exceed the maximum FDA labeled dose for the submitted diagnosis; and**
7. **Lost, stolen, or destroyed medication replacement requests will not be authorized.**

FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
CGRP Inhibitors

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

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:_____

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:

FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
CGRP Inhibitors

(PLEASE PRINT – ACCURACY IS IMPORTANT)

# 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

☐ **Renewal Requests:** Document clinical response to therapy: _____

_____

_____

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

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.*