Please complete ALL information below and fax your request to 1-888-671-5285

Aimovig™ Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Chronic migraines
❑ Episodic migraines
❑ Other diagnosis: ____ ICD-10 Code(s): ____________________________________

Provider specialty:

Was Aimovig prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

Was Aimovig prescribed by or in consultation with a headache specialist certified by the United Council for Neurologic Subspecialties? ❑ **Yes** ❑ **No**

Chronic migraines:

Does the patient have greater than or equal to 15 headache days per month? ❑ **Yes** ❑ **No**

Select if the patient has had an inadequate response or inability to tolerate a 4 week trial of the following prophylactic medications:

❑ Beta-blocker (atenolol, metoprolol, nadolol, propranolol, timolol)
❑ Divalproex sodium/ valproic acid
❑ SNRI antidepressants (duloxetine, venlafaxine)
❑ Topiramate
❑ Tricyclic antidepressants (amitriptyline, nortriptyline)

Has the patient had an inadequate response or inability to tolerate Botox (onabotulinumtoxin A)? ❑ **Yes** ❑ **No**

Episodic migraines:

Does the patient have 4 to14 headache days per month? ❑ **Yes** ❑ **No**

Select if the patient has had an inadequate response or inability to tolerate a 4 week trial of the following prophylactic medications:

❑ Beta-blocker (atenolol, metoprolol, nadolol, propranolol, timolol)
❑ Divalproex sodium/ valproic acid
❑ SNRI antidepressants (duloxetine, venlafaxine)
❑ Topiramate
❑ Tricyclic antidepressants (amitriptyline, nortriptyline)

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Aimovig™ Coverage Determination Request Form (Page 2 of 2)

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Reauthorization:
For reauthorization requests, answer the following:

Was Aimovig prescribed by or in consultation with a neurologist? ❑ **Yes** ❑ **No**

Was Aimovig prescribed by or in consultation with a headache specialist certified by the United Council for Neurologic Subspecialties? ❑ **Yes** ❑ **No**

Is there documentation of response to therapy as defined by a reduction in headache days per month (defined as at least 4 hours duration and moderate intensity)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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