FUTURE SCRIPTS

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

Aimovig™, Ajovy™, Emgality™ Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

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

Clinical Information:

Is the requested medication prescribed by or in consultation with a neurologist or pain specialist? ❑ **Yes** ❑ **No**

Select if the patient has had **failure** (after at least a 2 month trial) or **intolerance** to the following:

- ❑ Elavil (amitriptyline) **OR** Effexor (venlafaxine)
- ❑ Depakote/Depakote ER (divalproex sodium) **OR** Topamax (topiramate)
- ❑ One of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol

Select if the patient has **contraindication** to the following:

- ❑ Elavil (amitriptyline) **AND** Effexor (venlafaxine)
- ❑ Depakote/Depakote ER (divalproex sodium) **AND** Topamax (topiramate)
- ❑ **ALL** of the following beta blockers: atenolol, propranolol, nadolol, timolol, and metoprolol

Will the requested medication be used in combination with another CGRP inhibitor? ❑ **Yes** ❑ **No**

For **Ajovy** requests, has the patient had a trial and failure, contraindication or intolerance to Aimovig **AND** Emgality? ❑ **Yes** ❑ **No**

For chronic migraines, also answer the following:

Has medication overuse headache (MOH) been considered AND potentially offending medication(s) have been discontinued? ❑ **Yes** ❑ **No**

Does the patient have 15 or more headache days per month, of which at least 8 must be migraine days for at least 3 months? ❑ **Yes** ❑ **No**

For episodic migraines, also answer the following:

Does the patient have 4 to 14 migraine days per month (but no more than 14 headache days per month)? ❑ **Yes** ❑ **No**

Reauthorization:

Has the patient experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity? ❑ **Yes** ❑ **No**

Has the use of acute migraine medications (e.g., NSAIDs, triptans) decreased since the start of CGRP inhibitor therapy? ❑ **Yes** ❑ **No**

Is the requested medication prescribed by or in consultation with a neurologist or pain specialist? ❑ **Yes** ❑ **No**

For chronic migraines, also answer the following:

Does the patient continue to be monitored for medication overuse headache (MOH)? ❑ **Yes** ❑ **No**

Aimovig™, Ajovy™, Emgality™ Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

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