FUTURE SCRIPTS

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

Aimovig™ & Ajovy™ Prior Authorization Request Form

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	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic migraines (defined as 15 or more headache days/month)
❑ Episodic migraines (defined as 5-14 headache days/month)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the requested medication prescribed by or in consultation with a neurologist or headache specialist certified by the United Council for Neurologic Subspecialties, or a pain specialist? ❑ **Yes** ❑ **No**

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

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

For chronic migraines, also answer the following:

Has the patient previously been treated with onabotulinumtoxin A (Botox) for migraines? ❑ **Yes** ❑ **No**

Reauthorization:

For reauthorization requests, answer the following:

Is the requested medication prescribed by or in consultation with a neurologist or headache specialist certified by the United Council for Neurologic Subspecialties, or a pain specialist? ❑ **Yes** ❑ **No**

Is there documentation of response to therapy as defined by 50% 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?

_____

_____

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