



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:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Chronic migraines (defined as 15 or more headache days/month)	
<input type="checkbox"/> Episodic migraines (defined as 5-14 headache days/month)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<b>Clinical information:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<b>Select the prophylactic medications the patient has had an inadequate response to or inability to tolerate a 4 week trial of:</b>
<input type="checkbox"/> Beta-blocker: atenolol, metoprolol, nadolol, propranolol, timolol
<input type="checkbox"/> Divalproex sodium/ valproic acid
<input type="checkbox"/> SNRI antidepressants: duloxetine, venlafaxine
<input type="checkbox"/> Topiramate
<input type="checkbox"/> Tricyclic antidepressants: amitriptyline, nortriptyline

<b>For chronic migraines, also answer the following:</b> Has the patient previously been treated with onabotulinumtoxin A (Botox) for migraines? <input type="checkbox"/> Yes <input type="checkbox"/> No
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<b>Reauthorization:</b> <b>For reauthorization requests, answer the following:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Aimovig-Ajovy\_FSVF\_2019Aug-W