Reset Form Print Form

Prior Authorization Form
Migraine Medications:
Aimovig®, Ajovy®, Emgality®, Nurtec®, Ubrelvy®

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Member's Identification Number:

Date of Birth: – –

Member's Address:

City:

State:

ZIP:

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

DEA Number:

Office Phone Number: – –

Office Fax Number: – –

CLINICAL CRITERIA

1. What medication is being requested? _____
2. Is the medication requested by or in consultation with a specialist?
   ☐ Yes ☐ No

   If **Yes**, provide the specialty: _____

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

3. What is the member's diagnosis and headache frequency? (Check all that apply.)
   - ☐ Migraine with or without aura
   - ☐ Episodic cluster headache
   - ☐ ≥ 4 migraine days per month for at least 3 months
   - ☐ ≥ 15 headache days per month during the prior 6 months
   - ☐ 2 cluster periods lasting 7 days to 365 days separated by pain-free periods lasting at least 3 months
   - ☐ Other information regarding diagnosis or headache frequency

   _____

4. If diagnosis is migraine, was it based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria?
   ☐ Yes ☐ No
5. Has medication overuse headache been ruled out by trial and failure of titrating off acute migraine medications in the past?
   ☐ Yes ☐ No
6. Has the member tried and failed any of the medications listed below? (Check all that apply.)
   - ☐ Acetaminophen
   - ☐ Aimovig®
   - ☐ Angiotensin converting enzyme inhibitors/Angiotensin II receptor blockers (e.g., lisinopril, candesartan)
   - ☐ Antidepressants (e.g., amitriptyline, venlafaxine)
   - ☐ Anti-epileptics (e.g., valproate, topiramate)
   - ☐ Beta-blockers (e.g., propranolol, metoprolol, atenolol, timolol)
   - ☐ Caffeinated analgesic combination
   - ☐ Emgality®
   - ☐ Generic triptan (e.g., sumatriptan, rizatriptan)
   - ☐ Non-opioid analgesic
   - ☐ Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen)

   Provide drug names and trial dates:

   _____

7. Will the requested medication be taken in combination with botulinum agents (Botox®, Dysport®, Myobloc®, Xeomin®)?
   ☐ Yes ☐ No
8. Will the requested medication be taken in combination with other mediations in this class (Calcitonin gene-related peptide [CRGP] inhibitors)?
   ☐ Yes ☐ No

   If **Yes**, provide details: _____

(Form continued on next page.)

 MHID: MRXCOM13_01

Member's Last Name:

Member's First Name:

For Nurtec™ and Ubrelvy®:

9. Have the member's current medications been evaluated to rule out concomitant use of any strong CYP3A4 inhibitors, strong or moderate CYP3A inducers, or P-gp or breast cancer resistance protein (BCRP) inhibitors?
   ☐ Yes ☐ No

Renewal Requests for Aimovig®, Ajovy®, and Emgality®:

1. Will the requested medication be taken in combination with botulinum agents (Botox®, Dysport®, Myobloc®, Xeomin®)?
   ☐ Yes ☐ No
2. Has the member demonstrated significant decrease in the number, frequency, and/or intensity of headaches?
   ☐ Yes ☐ No
3. Has the member experienced an overall improvement in function?
   ☐ Yes ☐ No
4. Has the member experienced any unacceptable toxicity secondary to use of the requested medication?
   ☐ Yes ☐ No

Renewal Requests for Nurtec® and Ubrelvy®:

1. Have the member's current medications been evaluated to rule out concomitant use of any strong CYP3A4 inhibitors, strong or moderate CYP3a inducers, or P-gp or BCRP inhibitors?
   ☐ Yes ☐ No
2. How many headaches per month does the member average? _____
3. Is the member experiencing symptom improvement?
   ☐ Yes ☐ No
4. Is the member experiencing any treatment-limiting adverse reactions from the requested medication?
   ☐ Yes ☐ No

_____ _____

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-800-424-3260

Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034
Phone: 1-800-424-3312

 MHID: MRXCOM13_01