# *Migraine Calcitonin Agents: Preventative- Aimovig/Ajovy/Emgality/Vyepti/ Qulipta/Nurtec Prior Authorization Form*

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| **Member information** | | |
| 1. Member last name: | 2. Member first name: | |
| 3. Member ID #: | 4. Member date of birth: | 5. Member gender: |
| **Prescriber information** | | |
| 6. Prescribing provider NPI #: | | |
| 7. Requester contact information | | |
| Name: | | |
| Phone: | Ext: | |
| **Drug information** | | |
| 8. Drug name: | 9. Strength: | |
| 10. Quantity per 30 days: | | |
| 11. Length of therapy (in days): ☐ up to 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days | | |
| **Clinical information** | | |
| **Initial authorization for preventative treatment of migraines (injectables) (Aimovig, Ajovy, Emgality 120mg/ml, and Vyepti)** **Initial requests can be approved for up to 3-months for Aimovig, Emgality, Ajovy, and Vyepti for monthly dosing or up to 6 months for Ajovy quarterly dosing**: | | |
| 1. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? ☐ Yes ☐ No | | |
| 2. Is the member 18 years old or older? ☐ Yes ☐ No | | |
| 3. Does the member have medication over-use headache (MOH)? ☐ Yes ☐ No | | |
| 4. For beneficiaries that are women of childbearing age, is there a negative pregnancy test at baseline? ☐ Yes ☐ No | | |
| 5. Has the member experienced 4 or more migraine days per month for at least 3 months? ☐ Yes ☐ No | | |
| 6. Is the member utilizing prophylactic intervention modalities (for example, behavioral therapy, physical therapy, life-style modifications)? ☐ Yes ☐ No | | |
| 7. Has the member tried and failed at least a month or greater trial of medications from at least 2 different classes from the following list of oral medications: ☐ Yes ☐ No | | |
| a. Antidepressants (for example, amitriptyline, venlafaxine) | | |
| b. Beta Blockers (for example, propranolol, metoprolol, timolol, atenolol) | | |
| c. Anti-epileptics (for example, valproate, topiramate) | | |
| d. Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (for example, lisinopril, candesartan) | | |
| e. Calcium Channel Blockers (for example, verapamil, nimodipine)? | | |




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| Please list medications tried: |
| **Initial authorization for preventative treatment of migraines (orals) (Nurtec ODT, Qulipta)**<br>**Initial requests can be approved for up to 3-months |
| 1. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? ☐ Yes ☐ No |
| 2. Is the member 18 years old or older? ☐ Yes ☐ No |
| 3. Does the member have medication over-use headache (MOH)? ☐ Yes ☐ No |
| 4. Has the member experienced 4 or more migraine days per month for at least 3 months? ☐ Yes ☐ No |
| 5. Is the member utilizing prophylactic intervention modalities (for example, behavioral therapy, physical therapy, life-style modifications)? ☐ Yes ☐ No |
| 6. Has the member tried and failed at least 2 preferred injectable CGRPs? ☐ Yes ☐ No |
| **7. For Nurtec only** |
| 7a. Will the member use Nurtec concurrently with a strong CYP3A4 inhibitor? ☐ Yes ☐ No |
| 7b. Does the member have end-stage renal disease with a creatinine clearance (CrCl) less than 15ml/min? ☐ Yes ☐ No |
| **Initial authorization for treatment of Episodic Cluster Headache in Adults (Emgality 100mg/ml)**<br>****Initial requests can be approved for up to 3-months****:** |
| 1. Does the member have a diagnosis of Episodic Cluster Headache? ☐ Yes ☐ No |
| 2. Has the member experienced 2 cluster periods lasting from 7 days to 1 year (when treated) and separated by pain-free remission periods of at least 3 months? ☐ Yes ☐ No |
| 3. Is the member 18 years old or older? ☐ Yes ☐ No |
| 4. For beneficiaries that are women of childbearing age, is there a negative pregnancy test at baseline? ☐ Yes ☐ No |
| 5. Is the member utilizing prophylactic intervention modalities (for example, medication therapy)? ☐ Yes ☐ No |
| 6. Is the member receiving no more than 300mg (administrated as three consecutive injections of 100mg each) at the onset of the cluster headache period and then monthly until the end of the cluster headache period? ☐ Yes ☐ No |
| **For re-authorization for all diagnoses** **Re-authorization requests can be approved for up to 12 months**: |
| 1. Has the member experienced a significant decrease in the number, frequency, and/or intensity of headaches and/or decrease in the length of the cluster period? ☐ Yes ☐ No |
| 2. Has the member experienced an overall improvement in function with therapy? ☐ Yes ☐ No |
| 3. Does the member continue to utilize prophylactic intervention modalities (for example, behavioral therapy, physical therapy, life-style modifications)? ☐ Yes ☐ No |
| 4. If the member is a woman of childbearing age, is the provider continuing to monitor for pregnancy status? (not required for Qulipta or Nurtec) ☐ Yes ☐ No |
| 5. Is the member experiencing unacceptable toxicity (for example, intolerable injection site pain, constipation)? ☐ Yes ☐ No |

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| Signature of prescriber: | Date: |

**(Prescriber signature mandatory)**
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **844-376-2318**

Healthy Blue Provider Services: **844-594-5072**