BlueCross BlueShield of North Carolina | HealthyBlue

Migraine Calcitonin Gene Related Therapy Prior Authorization Form

Member Information

1. Member Last Name:_____ 2. 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: ☐ 3 Months ☐ 6 Months ☐ 12 Months Other: _____

Clinical Information

Migraine Treatment
Initial Request

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. If the member is a woman of childbearing age, has she had a negative pregnancy test at baseline? ☐ Yes ☐ No ☐ N/A
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 (e.g. behavioral therapy, physical therapy, life-style modifications)? ☐ Yes ☐ No Please list: _____
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
   Please list medications tried_____
   a. Antidepressants (e.g. amitriptyline, venlafaxine)
   b. Beta Blockers (e.g. propranolol, metoprolol, timolol, atenolol)
   c. Anti-epileptics (e.g. valproate, topiramate)
   d. Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g. lisinopril, candesartan)
   e. Calcium Channel Blockers (e.g. verapamil, nimodipine)

Episodic Cluster Headache Treatment
Initial Request

1. Does the member have a diagnosis of Episodic Cluster Headache with at least two cluster periods lasting from 7 days to 1 year (when untreated) and separated by pain-free remission periods of at least 3 months?
   ☐ Yes ☐ No
2. Is the member 18 years old or older? ☐ Yes ☐ No
3. If member is a woman of childbearing age, has she had negative pregnancy test at baseline?
   ☐ Yes ☐ No ☐ N/A
4. Is the member utilizing prophylactic intervention modalities (e.g.medication therapy)? ☐ Yes ☐ No
   Please list: _____
5. Is the member receiving no more than 300mg (administered 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

https://provider.healthybluenc.com

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Continuation Request for all diagnosis

1. Has the member demonstrated significant decrease in the number, frequency, and/or intensity of headaches? ☐ Yes ☐ No
2. Has the member experienced an overall improvement in function with therapy? ☐ Yes ☐ No
3. Has the member continued to utilize prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications, medications)? ☐ Yes ☐ No
4. If the member is a woman of childbearing age, is she continuing to be monitored for pregnancy status? ☐ Yes ☐ No ☐ N/A
5. Is the member experiencing unacceptable toxicity (e.g. intolerable injection site pain, constipation)? ☐Yes ☐ No

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 **1-844-376-2318**
Pharmacy PA Call Center: **1-844-594-5072**