# MIGRAINE PREVENTION AGENTS
(form effective 1/5/21)

**Keystone** First | PERFORMRx[SM] Next Generation Pharmacy Benefits

Fax to PerformRx[SM] at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

## PRIOR AUTHORIZATION REQUEST INFORMATION

| ☐ New request ☐ Renewal request | # of pages: | Name of office contact: |
|---|---|---|
| Contact's phone number: | | LTC facility contact/phone: |

## PATIENT INFORMATION

| Patient name: | | Patient ID #: | DOB: |
|---|---|---|---|
| Street address: | Apt. #: | City/state/zip: | |

## PRESCRIBER INFORMATION

| Prescriber name: | | Specialty: |
|---|---|---|
| State license #: | NPI: | MA Provider ID#: |
| Street address: | Suite #: | City/state/zip: |
| Phone: | | Fax: |

## PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

| Pharmacy Phone #: | Pharmacy Fax #: |
|---|---|

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

## CLINICAL INFORMATION

Product requested (clinical prior auth required):

☐ Aimovig 70 mg/ml autoinjector (1 autoinjector/package)
☐ Aimovig 140 mg/ml autoinjector (1autoinjector/package)
☐ Aimovig 140 mg dose (2 x 70 mg autoinjectors/package)
☐ Ajovy 225 mg/1.5 ml syringe
☐ Emgality 120 mg/ml pen
☐ Emgality 120 mg/ml syringe
☐ Emgality 300 mg (100 mg/ml syringe x 3)
☐ Vyepti IV Solution 100 mg/ml
☐ ______________________________
☐ ______________________________

| Dose/directions | Quantity: | Refills: |
|---|---|---|
| Diagnosis (submit documentation): | DX code (required): | |

Is the medication being prescribed by, or in consultation with, a neurologist or headache specialist? ☐ Yes *Submit documentation of consultation, if applicable.* ☐ No

## INITIAL REQUESTS FOR MIGRAINES

1. Has the patient averaged 4 or more migraine days per month over the past 3 months? ☐ Yes ☐ No
2. Does the patient have a confirmed diagnosis of migraine (with or without aura) according to the current International Headache Society Classification of Headache Disorders?
   ☐ Yes - *Submit documentation of diagnosis.* ☐ No
3. Does the patient have a history of trial and failure of at least one drug from two of the following three classes?
   ☐ anticonvulsants (e.g., divalproex, topiramate, valproic acid) ☐ antidepressants (e.g., amitriptyline, venlafaxine) ☐ beta blockers (e.g., metoprolol, propranolol, timolol)
   ☐ Yes - List medications tried:
   ☐ No
4. Will the patient be using the requested drug with another migraine prevention agent or a small molecule CGRP receptor antagonist (gepant)?
   ☐ Yes - *Submit documentation of consultation, if applicable.* ☐ No
5. Request for a non-preferred agent: Has the patient tried and failed the preferred CGRP Inhibitor, Emgality? ☐ Yes ☐ No
6. Provide average number of migraine days and headache days per month:

## INITIAL REQUESTS FOR EPISODIC CLUSTER HEADACHE

1. Does the patient have confirmed diagnosis of episodic cluster headache according to the current International Headache Society Classification of Headache Disorders?
   ☐ Yes - *Submit documentation of diagnosis.* ☐ No
2. Does the patient have a history of trial and failure, contraindication, or intolerance of a preventive medication recommended by current consensus guidelines for episodic cluster headaches?
   ☐ Yes - *List medications tried:*
   ☐ No
3. Will the patient be using the requested drug with another migraine prevention agent or a small molecule CGRP receptor antagonist (gepant)? ☐ Yes ☐ No

## RENEWAL REQUESTS

1. Since starting the requested medication, did the patient experience a reduction in the average number of headache or migraine days per month or decrease in severity and/or duration of headaches or migraines? ☐ Yes - S*ubmit documentation of clinical response.* ☐ No

## PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

| Prescriber signature: | Date: |
|---|---|

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