Print Reset

Prior Authorization Request Prescriber Fax
Calcitonin Gene-Related Peptides (CGRP)
Fax this form to 800-424-3260

Magellan Rx partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews. Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information visit https://magellanrx.com.

What is the priority level of this request?

- ☐ Standard
- ☐ Date of service (if applicable): _____
- ☐ Urgent (**Note**: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

Today's Date: _____

PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____

Patient ID: _____ Date of Birth: _____ Patient Phone: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Height: _____ ☐ in. ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Email: _____

Prescriber NPI: _____ DEA: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: _____

If renewal, duration of therapy (specific dates): _____ to _____

CRITERIA

Note: Please attach any additional information that should be considered with this request.

For All requests:

1. Is the patient currently treated with the requested agent?
   ☐ Yes ☐ No
2. Does the patient have any FDA-labeled contraindications to the requested agent?
   ☐ Yes ☐ No

   If Yes, specify contraindication(s): _____
3. Is the patient's age within FDA labeling for the requested diagnosis for the requested agent?
   ☐ Yes ☐ No

   If No, is there information to support using the requested agent for the patient's age for the requested diagnosis?
   ☐ Yes ☐ No

   If Yes, provide supporting information: _____
4. Has medication overuse headache been ruled out?
   ☐ Yes ☐ No
5. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max).

   _____

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

6. Please list all medications that the patient has previously tried and failed for treatment of this diagnosis. (Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products.)

   Medication: _____ Type: _____

   Date (from): _____ Date (to): _____

   Medication: _____ Type: _____

   Date (from): _____ Date (to): _____

   Medication: _____ Type: _____

   Date (from): _____ Date (to): _____

Migraine prophylaxis:

7. Will the patient be using the requested agent in combination with another prophylactic CGRP agent for the requested diagnosis?

   ☐ Yes ☐ No

8. Does the patient have a diagnosis of chronic migraine (≥ 15 headache days per month)?

   ☐ Yes ☐ No

   If Yes, has the patient had ≥ 15 migraine-like or tension-like headache days per month for at least 3 months?

   ☐ Yes ☐ No

   If Yes, has the patient had ≥ 8 migraine headache days per month for at least 3 months?

   ☐ Yes ☐ No

9. Does the patient have a diagnosis of episodic migraine (fewer than 15 headache days per month)?

   ☐ Yes ☐ No

   If Yes, does the patient have any of the following? Select all that apply.

   ☐ > 4 migraine headache days per month

   ☐ Migraine headaches last > 12 hours

   ☐ Tried and received inadequate response to acute therapies

   ☐ Serious side effects to acute therapies

   ☐ At risk for medication overuse headache without preventive therapy

   ☐ Contraindications to acute therapies

   ☐ Migraine attacks cause significant disability or diminished quality of life despite appropriate therapy with acute agents only

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

10. Has the patient tried and had an inadequate response to at least one migraine prophylaxis class (e.g., anticonvulsants [e.g., divalproex, valproate, topiramate], beta blockers [e.g., atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [e.g., amitriptyline, venlafaxine], candesartan) after an adequate trial as defined by **both** of the following?
    - The trial length was at least 6 weeks at generally accepted doses
    - The patient was > 80% adherent to the prophylaxis agent during the trial

    ☐ Yes ☐ No

    If Yes, specify agent(s): _____

    If No, does the patient have an intolerance or hypersensitivity to therapy with at least one migraine prophylaxis class listed above?

    ☐ Yes ☐ No

    If Yes, explain intolerance/hypersensitivity:

    _____

    If No, does the patient have an FDA-labeled contraindication to therapy with **all** migraine prophylaxis agents listed above?

    ☐ Yes ☐ No

    If Yes, specify contraindication(s): _____

Episodic cluster headache requests:

11. Has the patient had at least 5 cluster headache attacks?

    ☐ Yes ☐ No

12. Has the patient had at least two cluster periods lasting 7-365 days?

    ☐ Yes ☐ No

13. Are the patient's cluster periods separated by a pain-free remission period of ≥ 3 months?

    ☐ Yes ☐ No

14. Has the patient tried and had an inadequate response to verapamil, melatonin, corticosteroids, topiramate, or lithium?

    ☐ Yes ☐ No

    If Yes, specify agent(s): _____

    If No, does the patient have an intolerance or hypersensitivity to verapamil, melatonin, corticosteroids, topiramate, or lithium?

    ☐ Yes ☐ No

    If Yes, explain intolerance/hypersensitivity:

    _____

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

If No, does the patient have an FDA labeled contraindication to **all** of the following: verapamil, melatonin, corticosteroids, topiramate, **and** lithium?

☐ Yes ☐ No

If Yes, specify contraindication(s): _____

Acute migraine treatment requests:

15. Has the patient tried and had an inadequate response to at least one triptan agent?

☐ Yes ☐ No

If Yes, specify agent(s): _____

If No, does the patient have an intolerance or hypersensitivity to a triptan agent?

☐ Yes ☐ No

If Yes, explain intolerance/hypersensitivity:

_____

If No, does the patient have an FDA labeled contraindication to **all** triptan agents?

☐ Yes ☐ No

If Yes, specify contraindication(s): _____

16. Will the patient use the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP) for the requested indication?

☐ Yes ☐ No

RENEWAL REQUESTS

17. Has the patient had clinical benefit with the requested agent?

☐ Yes ☐ No

Episodic cluster headache:

18. Has the patient had improvement in cluster headache management with the requested agent?

☐ Yes ☐ No

If Yes, explain improvement: _____

Migraine prophylaxis:

19. Has the patient had improvement in migraine prevention (such as reduced migraine headache days, reduced migraine frequency, or reduced use of acute abortive migraine medication) with the requested agent?

☐ Yes ☐ No

If Yes, explain improvement: _____

20. Will the patient be using the requested agent in combination with another prophylactic CGRP for the requested diagnosis?

☐ Yes ☐ No

Patient's Name (Last, First): _____

RENEWAL REQUESTS (CONTINUED)

Acute migraine treatment:

21. Has the patient had improvement in acute migraine management with the requested agent?
    ☐ Yes ☐ No

    If Yes, explain improvement: _____

22. Will the patient be using the requested agent in combination with another acute migraine agent (e.g., triptan, 5HT-1F, ergotamine, acute CGRP)?
    ☐ Yes ☐ No

☐ Attachments

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

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

Please fax or mail this form to:

Magellan Rx Management, LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 1-800-424-3312

Fax this form to 800-424-3260