REALRx

PRIOR AUTHORIZATION REQUEST FORM

Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists for Migraine Prevention

Aimovig®, Ajovy®, Emaglity®, Nurtec®, Qulipta™

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Ajovy® (fremanezumab-vfrm), ☐ Emgality® (galcanezumab-gnlm)
Non-preferred: ☐ Aimovig® (erenumab-aooe), ☐ Nurtec® (rimegepant), ☐ Qulipta™ (atogepant)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
EPISODIC MIGRAINE, CHRONIC MIGRAINE			
1. Does the member have a diagnosis of episodic or chronic migraines?	☐	☐	**Please provide documentation**
2. Has the member had at least a **3-month trial and failure of a beta-blocker** (propranolol, metoprolol, etc.) and **at least 1** of the following: • Calcium channel blocker (verapamil, nifedipine, etc.) • Antidepressant (amitriptyline, venlafaxine, etc.) • Anticonvulsant (topiramate, gabapentin, divalproex, etc.) • Angiotensin converting enzyme (ACE) inhibitor (Lisinopril, etc.), OR **If a beta-blocker cannot be tried, does documentation show a trial and failure of at least 2 of the agents listed above?**	☐	☐	**Please provide documentation** If a beta-blocker cannot be tried, does documentation show a trial and failure of at least 2 of the agents listed to the left?
3. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication or Reyvow (lasmiditan) to treat migraine headaches?	☐	☐	**Please provide documentation**

4. If the request is for Aimovig (erenumab-aooe), for migraine prevention, has the member tried and failed, or have a contraindication to, ALL of the following? • Ajovy®(Fremanezumab-vfrm) • Emgality®(galcanezumab-gnlm)	☐	☐	**Please provide documentation**
5. If the request is for Nurtec® (rimegepant) for migraine prevention, has the member tried and failed, or have a contraindication to, ALL of the following? • Ajovy®(Fremanezumab-vfrm) • Emgality®(galcanezumab-gnlm) • Aimvog®(erenumab-aooe) • Qulipta®(atogepant)	☐	☐	**Please provide documentation**
6. If the member is requesting Qulipta™ (atogepant) for migraine prevention, does the member have a physical or mental disability that makes an injection not possible OR has the member tried and failed, or have a contraindication to, ALL of the following? • Ajovy®(Fremanezumab-vfrm) • Emgality®(galcanezumab-gnlm) • Aimvog®(erenumab-aooe)	☐	☐	**Please provide documentation**
CLUSTER HEADACHE			
1. If the request is for Emgality® (galcanezumab) to treat cluster headache, does documentation show at least 2 cluster periods with at least 5 attacks lasting 7-days to 1 year (when untreated) and separated by pain-free remission periods of 3 months or more?	☐	☐	**Please provide documentation**
2. Has the member had at least a 3-month trial and failure or contraindication/intolerance of verapamil titrated up to the maximum tolerated FDA-approved dose?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show the member had a positive response to therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-016
Origination Date: 05/23/2018
Reviewed/Revised Date: 01/17/2024
Next Review Date: 01/17/2025
Current Effective Date: 02/01/2024