PRIOR AUTHORIZATION REQUEST
Aimovig

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Has the member been diagnosed as having an episodic or chronic migraine?
2. ☐ Yes ☐ No Has the member experienced greater than 4 migraine days per month for at least 3 months?
3. ☐ Yes ☐ No Is Aimovig being prescribed by or in consultation with neurologist, headache or pain specialist?
4. ☐ Yes ☐ No Has the member experienced failure of at least 2 of the following oral migraine preventative therapies, each for 8 weeks and from different therapeutic classes, unless contraindicated or clinically significant adverse effects are experienced: antiepileptic drugs (for example, divalproex sodium, sodium valproate, topiramate), beta-blockers (for example, metoprolol, propranolol, timolol), antidepressants (for example, amitriptyline, venlafaxine)?
5. ☐ Yes ☐ No Is Aimovig being prescribed concurrently with Botox or other injectable CGRP inhibitors (for example, Ajovy, Emgality)?
6. ☐ Yes ☐ No Is Aimovig being prescribed such that the dose does not exceed 70 mg (1 injection) once monthly?
7. Please provide medical justification for prescribing dose of 140 mg (1 injection) once monthly.

_____

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851