PRIOR AUTHORIZATION REQUEST
Emgality

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 member experienced greater than or equal to 4 migraine days per month for at least 3 months?
3. ☐ Yes ☐ No Is the medication prescribed by or in consultation with a neurologist, headache or pain specialist?
4. ☐ Yes ☐ No Has the patient experienced a 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 (e.g., metoprolol, propranolol, timolol), antidepressants (for example, amitriptyline, venlafaxine)?
5. ☐ Yes ☐ No Is Emgality being prescribed concurrently with Botox or other injectable CGRP inhibitors (for example, Aimovig, Ajovy)?
6. ☐ Yes ☐ No Is the drug being prescribed such that dosing does not exceed a loading dose of 240 mg (2 injections) once OR a maintenance dose of 120 mg (1 injection) once monthly?

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

_____

_____

SECTION B Physician Signature

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

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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