PRIOR AUTHORIZATION REQUEST

Ajovy

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
2	Is the requested medication prescribed by or in consultation with a neurologist, headache or pain specialist? [If no, no further questions.]	Yes	No
3	What is the diagnosis or indication? [] Migraine headache prevention (If checked, go to 4)		

If you have any questions, call: 1-888-258-8250

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	[] Other (If checked, no further questions)		
4	Does the patient have greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventive medication)? [If no, no further questions.]	Yes	No
5	Has the patient tried at least two standard prophylactic (preventive) pharmacologic therapies, each from a different pharmacologic class? [NOTE: Examples of standard prophylactic (preventive) pharmacologic therapies include angiotensin receptor blocker, angiotensin converting enzyme inhibitor, beta-blocker, calcium channel blocker.] [If no, no further questions.]	Yes	No
6	Has the patient had inadequate efficacy to both of those standard prophylactic (preventive) pharmacologic therapies, according to the prescriber? [If yes, skip to question 9.]	Yes	No
7	Has the patient experienced adverse event(s) severe enough to warrant discontinuation of both of those standard prophylactic (preventive) pharmacologic therapies, according to the prescriber? [If yes, skip to question 9.]	Yes	No
8	Has the patient had inadequate efficacy to one standard prophylactic (preventive) pharmacologic therapy and has experienced adverse event(s) severe enough to warrant discontinuation to another standard prophylactic (preventive) pharmacologic therapy, according to the prescriber? [If no, no further questions.]	Yes	No
9	Is the patient taking a calcitonin gene-related peptide (CGRP) inhibitor for migraine headache prevention? [NOTE: Calcitonin gene-related peptide CGRP inhibitors used for migraine headache prevention are Aimovig (erenumab-aooe injection), Ajovy, Emgality (galcanezumab-gnlm injection), and Vyepti (eptinezumab-jjmr injection). [If yes, skip to question 12.]	Yes	No
10	Has the patient tried at least one triptan therapy? [If yes, no further questions.]	Yes	No
11	Does the patient have a contraindication to triptan(s) according to the prescriber? [NOTE: Examples of contraindications to triptans include a history of coronary artery disease; cardiac accessory conduction pathway disorders; history of stroke, transient ischemic attack, or hemiplegic or basilar migraine; peripheral vascular disease; ischemic bowel disease; uncontrolled hypertension; or severe hepatic impairment.] [If yes, no further questions.]	Yes	No
12	Is the patient currently taking the requested medication and has had a significant	Yes	No

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	clinical benefit from the medication, as determined by the prescriber? [NOTE: Examples of significant clinical benefit include a reduction in the overall number of migraine days per month or a reduction in number of severe migraine days per month from the time that the requested medication was initiated.] [If yes, no further questions.]		
13	Is the patient switching from a different calcitonin gene-related peptide (CGRP) inhibitor for migraine headache prevention to the requested medication?	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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 authorization as per Plan policy and procedures.

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