maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Emgality

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 greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
2	Is the requested medication prescribed by or in consultation with a neurologist or a physician with specialized training in headaches? [If no, no further questions.]	Yes	No
3	What is the diagnosis or indication? [] Episodic or chronic migraine (if checked, go to 4)		

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

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[] Episodic cluster headache (if checked, go to 8)

[] Other (If checked, no further questions)

4	Has the patient experienced greater than or equal to 4 migraine days per month for at least 3 months? [If no, no further questions.]	Yes	No
5	Has the patient experienced failure of at least one agent from the following class, for 8 weeks, unless contraindicated or clinically significant adverse effects are experienced: • beta-blockers (for example, metoprolol, propranolol, timolol)? [If no, no further questions.]	Yes	No
6	Is the requested medication being prescribed concurrently with Botox or other injectable calcitonin gene-related peptide (CGRP) inhibitors (for example, Aimovig, Ajovy)? [If yes, no further questions.]	Yes	No
7	Is the requested medication 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? [No further questions.]	Yes	No
8	Has the patient been diagnosed with cluster headaches (demonstrated by experiencing least 2 headache attacks ranging from 30 to 180 minutes that last for at least 7 days to one year and separated by a remission period of at least 3 months)? [If no, no further questions.]	Yes	No
9	Has the patient experienced failure of at least one agent from each of the TWO following classes for 8 weeks, unless contraindicated or clinically significant adverse effects are experienced: • non-dihydropyridine calcium channel blocker (for example, verapamil), • corticosteroids taper dose for at least a duration of 2 weeks (for example, prednisone)? [If no, no further questions.]	Yes	No
10	Is the requested medication being prescribed concurrently with Botox or other injectable calcitonin gene-related peptide (CGRP) inhibitors (for example, Aimovig, Ajovy)? [If yes, no further questions.]	Yes	No
11	Is the requested medication for Emgality 100mg/mL, with 3 prefilled syringes per month? [No further questions.]	Yes	No

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[NOTE: Emgality 100mg/mL prefilled syringe is only covered for cluster headaches.]

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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