PRIOR AUTHORIZATION REQUEST

Reyvow

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 requested medication prescribed by or in consultation with a neurologist or pain management specialist with expertise in treating headaches? [If no, no further questions.]	Yes	No
2	Is the requested medication prescribed in combination with another calcitonin gene-related peptide (CGRP) inhibitor or 5-hydroxytryptamine receptor 1F (5HT-1F) agent? [If yes, no further questions.]	Yes	No

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

Version 07.2025

PRIOR AUTHORIZATION REQUEST

3	Does the prescribed dose exceed FDA approved label dosing for indication? [If yes, no further questions.]	Yes	No
4	Is the patient currently receiving the requested medication? [If no, skip to question 9.]	Yes	No
5	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
6	Has the patient responded to therapy as determined by the prescriber (for example, improvement in migraine frequency and severity, reduction in migraine days, etc.)? [If no, no further questions.]	Yes	No
7	Does the patient have a previously approved PA on file with the current plan? [If yes, no further questions.] [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]	Yes	No
8	Has the patient responded to therapy as determined by the prescriber (for example, improvement in migraine frequency and severity, reduction in migraine days, etc.)? [If no, no further questions.]	Yes	No
9	Is the requested medication prescribed for the acute treatment of migraine? [If no, no further questions.]	Yes	No
10	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
11	Does the patient have a diagnosis of migraine with or without aura? [If no, no further questions.]	Yes	No
12	Has the patient experienced greater than 4 migraine days per month for at least 3 months? [If no, no further questions.]	Yes	No
13	Has the patient experienced failure of at least one agent from the following class, for 8 weeks: • beta-blockers (for example, metoprolol, propranolol, timolol)? [If yes, skip to question 15.]	Yes	No
14	Has the patient had a contraindication or experienced clinically significant adverse effects which prevent the use of at least one beta-blocker (for example, metoprolol, propranolol, timolol)? [If no, no further questions.]	Yes	No

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15	Has the patient tried and failed at least TWO triptan therapies, at up to maximally indicated doses? [If yes, skip to question 17.]	Yes	No
16	Has the patient had a contraindication or experienced clinically significant adverse effects to triptan therapies? [If no, no further questions.]	Yes	No
17	Has the patient tried and failed preferred calcitonin gene-related peptide (CGRP) inhibitors, Aimovig and Emgality?	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.

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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