



# 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 request an INITIAL or CONTINUATION of therapy?	
	<input type="checkbox"/> Initial (If checked, go to 7)	
	<input type="checkbox"/> Continuation (If checked, go to 2)	
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes      No

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

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3	<p>Does the patient have a previously approved prior authorization (PA) on file with the current plan?                      [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.]                      [If no, skip to question 7.]</p>	Yes	No
4	<p>Is the requested medication being prescribed by or in consultation with a neurologist, headache or pain specialist?                      [If no, no further questions.]</p>	Yes	No
5	<p>Will the requested medication be prescribed concurrently with Botox or other injectable calcitonin gene-related peptide (CGRP) inhibitors (for example, Ajovy, Aimovig)?                      [If yes, no further questions.]</p>	Yes	No
6	<p>Has documentation been submitted to confirm that the patient has experienced a clinical response to therapy as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation.                      [NOTE: Examples of a clinical response include positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity.]                      [No further questions.]</p>	Yes	No
7	<p>What is the diagnosis or indication?   <input type="checkbox"/> Migraine prevention (If checked, go to 8)   <input type="checkbox"/> Episodic cluster headache (If checked, go to 14)   <input type="checkbox"/> Other (If checked, no further questions)</p>		
8	<p>Is the patient greater than or equal to 18 years of age?                      [If no, no further questions.]</p>	Yes	No
9	<p>Has the patient experienced greater than or equal to 4 migraine days per month for at least 3 months?                      [If no, no further questions.]</p>	Yes	No
10	<p>Has the patient tried at least TWO standard prophylactic (preventive) pharmacologic therapies for 8 weeks, unless contraindicated or clinically significant adverse effects are experienced? ACTION REQUIRED: Submit supporting documentation.                      [If no, no further questions.]</p>	Yes	No
11	<p>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.]</p>	Yes	No
12	<p>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.]</p>	Yes	No
13	<p>Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved labeled dosing for the indication migraine headache prevention?</p>	Yes	No

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[Note: Dosing: loading dose of 240 mg once OR a maintenance dose of 120 mg once monthly.]  
 [No further questions.]

- |    |   |     |    |
|----|---|-----|----|
| 14 | Is the patient greater than or equal to 18 years of age?<br>[If no, no further questions.]  | Yes | No |
| 15 | 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)?<br>[If no, no further questions.]                            | Yes | No |
| 16 | Has the patient experienced failure of at least TWO agents from different classes (triptans, ergotamine derivates, NSAIDs) for 8 weeks, unless contraindicated or clinically significant adverse effects are experienced? ACTION REQUIRED: Submit supporting documentation.<br>[If no, no further questions.] | Yes | No |
| 17 | Is the requested medication being prescribed concurrently with Botox or other injectable calcitonin gene-related peptide (CGRP) inhibitors (for example, Aimovig, Ajovy)?<br>[If yes, no further questions.]  | Yes | No |
| 18 | Is the requested medication prescribed by or in consultation with a neurologist or a physician with specialized training in headaches?<br>[If no, no further questions.]  | Yes | No |
| 19 | Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved labeled dosing for the indication migraine headache prevention?<br>[Note: Dosing: 100 mg/mL, 3 prefilled syringes per month.]  | 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,

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