PRIOR AUTHORIZATION REQUEST

AIMOVIG

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?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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

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3	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.]	Yes	No
4	Is the requested medication being prescribed by or in consultation with a neurologist, headache specialist, or pain specialist? [If no, no further questions.]	Yes	No
5	Will the requested medication be prescribed concurrently with Botox or other calcitonin gene-related peptide (CGRP) inhibitors (for example, Ajovy, Emgality, Ubrelvy, Nurtec, Qulipta)? [If yes, no further questions.]	Yes	No
6	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.]	Yes	No
7	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
8	Has the patient been diagnosed as having an episodic or chronic migraine? [If no, no further questions.]	Yes	No
9	Has the patient experienced greater than 4 migraine headache days per month for at least 3 months? [If no, no further questions.]	Yes	No
10	Has the patient experienced failure of at least TWO agents from different classes for 12 weeks, unless contraindicated or clinically significant adverse effects are experienced in all treatment options? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.] [NOTE: Agent Classes - Beta blockers, calcium channel blockers, ACE/ARB.]	Yes	No
11	Is the requested medication being prescribed concurrently with Botox or other calcitonin gene-related peptide (CGRP) inhibitors (for example, Ajovy, Emgality, Ubrelvy, Nurtec, Qulipta)? [If yes, no further questions.]	Yes	No
12	Is the requested medication being prescribed by or in consultation with a neurologist, headache specialist, or pain specialist?	Yes	No

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	[If no, no further questions.]		
13	Is the requested medication being prescribed such that the dose does not exceed 70 mg (1 injection) once monthly? [If yes, no further questions.]	Yes	No
14	Has documentation been provided to indicate the patient has tried and failed 70 mg (1 injection) monthly dosing? ACTION REQUIRED: Submit supporting documentation. Documentation may include patient chart notes, prescription claims records, and/or prescription receipts.	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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