HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM

CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAGONIST MEDICATIONS

Aimovig®, Ajovy®, Emaglity®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Ajovy® (fremanezumab-vfrm) ☐ Emgality® (galcanezumab-gnlm)
Non-preferred: ☐ Aimovig® (erenumab-aooe)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
EPISODIC MIGRAINE, CHRONIC MIGRAINE			
1. Does the member have a diagnosis of one of the following? • Episodic migraines, defined as 4 to 14 migraine days per month, but no more than 15 headache days per month • Chronic migraines, defined as 15 or more headache days per month, of which at least 8 must be migraine days	☐	☐	**Please provide documentation**
2. Has the member had at least a **3 month trial and failure of a beta blocker** (propranolol, metoprolol, etc.) and **at least 1** of the following: • Calcium channel blocker (verapamil, nifedipine, etc.) • Antidepressant (amitriptyline, venlafaxine, etc.) • Anticonvulsant (topiramate, gabapentin, divalproex, etc.) • Angiotensin converting enzyme (ACE) inhibitor (Lisinopril, etc.) **If a beta blocker cannot be tried, member must show a trial and failure to at least 2 agents listed above.**	☐	☐	**Please provide documentation**
CLUSTER HEADACHE			
1. Does the member have a diagnosis of the following? • Cluster headache, defined as at least 2 cluster periods with at least 5 attacks lasting 7 days to 1 year (when	☐	☐	**Please provide documentation**

untreated) and separated by pain-free remission periods of 3 months or more			
2. Has the member had at least a 3 month trial and failure of verapamil titrated up to the maximum tolerated dose?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show the member had a positive response to therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

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Policy PHARM-016
Origination Date: 05/23/2018
Reviewed/Revised Date: 11/23/2020
Next Review Date: 11/23/2021
Current Effective Date: 12/01/2020