

## Migraine Calcitonin Agents - Preventative: Aimovig, Ajovy, Emgality, Vyepti, Qulipta, Nurtec

### Member Information

1. Last Name: _____	2. First Name: _____	
3. Trillium ID #: _____	4. Date of Birth: _____	5. Gender: _____

### Prescriber Information

1. Prescriber Name: _____	2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____	
4. Mailing Address: _____	City: _____ State: _____ Zip: _____
5. Phone #: _____	Ext. _____ Fax #: _____

### Drug Information

1. Drug Name: _____	2. Strength: _____	3. Quantity Per 30 Days: _____
4. Length of Therapy (in Days): <input type="checkbox"/> up to 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days		

### Clinical Information

#### Initial authorization for PREVENTATIVE treatment of Migraines (INJECTABLES) (Aimovig, Ajovy, Emgality 120mg/ml, and Vyepti)

**\*\*Initial requests can be approved for up to 3-months for Aimovig, Emgality, Ajovy, and Vyepti for monthly dosing or up to 6 months for Ajovy quarterly dosing\*\*:**

1. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria?  Yes  No
2. Is the member 18 years old or older?  Yes  No
3. Does the member have medication over-use headache (MOH)?  Yes  No
4. For members that are women of childbearing age, is there a negative pregnancy test at baseline?  Yes  No
5. Has the member experienced 4 or more migraine days per month for at least 3 months?  Yes  No
6. Is the member utilizing prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)?  Yes  No
7. Has the member tried and failed at least a month or greater trial of medications from at least 2 different classes from the following list of oral medications: 1. Antidepressants (e.g. amitriptyline, venlafaxine) 2. Beta Blockers (e.g. propranolol, metoprolol, timolol, atenolol) 3. Anti-epileptics (e.g. valproate, topiramate) 4. Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g. lisinopril, candesartan) 5. Calcium Channel Blockers (e.g. verapamil, nimodipine)?  Yes  No Please list medications tried: \_\_\_\_\_

#### Initial authorization for PREVENTATIVE treatment of Migraines (ORALS) (Nurtec ODT, Qulipta)

**\*\*Initial requests can be approved for up to 3- months**

1. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria?  Yes  No
2. Is the member 18 years old or older?  Yes  No
3. Does the member have medication over-use headache (MOH)?  Yes  No
4. Has the member experienced 4 or more migraine days per month for at least 3 months?  Yes  No
5. Is the member utilizing prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)?  Yes  No
6. Has the member tried and failed at least 2 preferred injectable CGRPs?  Yes  No
7. **For Nurtec ONLY**
  - 7a. Will the Member use Nurtec concurrently with a strong CYP3A4 inhibitor?  Yes  No
  - 7b. Does the Member have end-stage renal disease with a creatinine clearance (CrCl) less than 15ml/min?  
 Yes  No

#### Initial authorization for treatment of Episodic Cluster Headache in Adults (Emgality 100mg/ml)

**\*\*Initial requests can be approved for up to 3- months\*\*:**

1. Does the member have a diagnosis of Episodic Cluster Headache?  Yes  No

**Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277**

2. Has the member experienced 2 cluster periods lasting from 7 days to 1 year (when treated) and separated by pain-free remission periods of at least 3 months?  Yes  No
3. Is the member 18 years old or older?  Yes  No
4. For members that are women of childbearing age, is there a negative pregnancy test at baseline?  Yes  No
5. Is the member utilizing prophylactic intervention modalities (e.g. medication therapy)?  Yes  No
6. Is the member receiving no more than 300mg (administrated as three consecutive injections of 100mg each) at the onset of the cluster headache period and then monthly until the end of the cluster headache period?  
 Yes  No

**For re-authorization for all diagnoses \*\*Re-authorization requests can be approved for up to 12 months\*\*:**

1. Has the member experienced a significant decrease in the number, frequency, and/or intensity of headaches and/or decrease in the length of the cluster period?  Yes  No
2. Has the member experienced an overall improvement in function with therapy?  Yes  No
3. Does the member continue to utilize prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)?  Yes  No
4. If the member is a woman of childbearing age, is the provider continuing to monitor for pregnancy status? (not required for Qulipta or Nurtec)  Yes  No
5. Is the member experiencing unacceptable toxicity (e.g. intolerable injection site pain, constipation)?  
 Yes  No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.