



Fax to PerformRxSM at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	# of pages:	Name of office contact:
Contact's phone number:	LTC facility contact/phone:	

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID#:
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

CLINICAL INFORMATION

Product requested (clinical prior auth required):

<input type="checkbox"/> Aimovig 70 mg/ml autoinjector (1 autoinjector/package)	<input type="checkbox"/> Ajovy 225 mg/1.5 ml autoinjector	<input type="checkbox"/> Nurtec ODT 75 mg
<input type="checkbox"/> Aimovig 140 mg/ml autoinjector (1 autoinjector/package)	<input type="checkbox"/> Emgality 120 mg/ml autoinjector	<input type="checkbox"/> Vyepti IV Solution 100 mg/ml
<input type="checkbox"/> Aimovig 140 mg dose (2 x 70 mg autoinjectors/package)	<input type="checkbox"/> Emgality 120 mg/ml syringe	<input type="checkbox"/> _____
<input type="checkbox"/> Ajovy 225 mg/1.5 ml syringe	<input type="checkbox"/> Emgality 300 mg (100 mg/ml syringe x 3)	<input type="checkbox"/> _____

Dose/directions	Quantity:	Refills:
Diagnosis (submit documentation):	DX code (required):	
Is the medication being prescribed by, or in consultation with, a neurologist or headache specialist? <input type="checkbox"/> Yes <i>Submit documentation of consultation, if applicable.</i> <input type="checkbox"/> No		

ALL INITIAL REQUESTS

- If the patient is currently using a Migraine Prevention Agent, one of the following:
 - Will discontinue use of that Migraine Prevention Agent prior to starting the requested Migraine Prevention Agent
 - Has a medical reason for concomitant use of both Migraine Prevention Agents that is supported by peer-reviewed literature or national treatment guidelines. Please explain:
- For a gepant (such as Nurtec ODT), if currently using a different gepant (such as Ubrovelvy), one of the following:
 - Will discontinue use of that gepant prior to starting the requested gepant
 - Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines. Please explain:
- For a non-preferred agent: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication?
 - Yes No
 - If yes, select medications tried.
 - Aimovig Emgality Nurtec ODT Other:

INITIAL REQUESTS FOR MIGRAINES

- Has the patient averaged 4 or more migraine days per month over the past 3 months? Yes No
- For Nurtec ODT: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication?
 - Yes No
 - If yes, select medications tried.
 - Aimovig Emgality Other:
- Does the patient have a confirmed diagnosis of migraine (with or without aura) according to the current International Headache Society Classification of Headache Disorders?
 - Yes No
- Does the patient have a history of trial and failure of or contraindication or intolerance to at least one drug from two of the following three classes?
 - anticonvulsants (e.g., divalproex, topiramate, valproic acid) antidepressants (e.g., amitriptyline, venlafaxine) beta blockers (e.g., metoprolol, propranolol, timolol)
 - Yes - List medications tried:
 - No
- Provide average number of migraine days and headache days per month at baseline:

MIGRAINE PREVENTION AGENTS

INITIAL REQUESTS FOR EPISODIC CLUSTER HEADACHE

1. Does the patient have confirmed diagnosis of episodic cluster headache according to the current International Headache Society Classification of Headache Disorders?
 Yes No
2. Does the patient have a history of trial and failure, contraindication, or intolerance of a preventive medication recommended by current consensus guidelines for episodic cluster headaches?
 Yes - *List medications tried:*
 No

RENEWAL REQUESTS

1. For the prevention of migraine: Since starting the requested medication, did the patient experience one of the following:
 Reduction in the average number of migraine days per month from baseline
 Decrease in severity or duration of migraines from baseline
2. For episodic cluster headache: Since starting the requested medication, did the patient experience a reduction in cluster headache frequency from baseline? Yes No
3. For Nurtec ODT, for the prevention of migraine: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication? Yes No
If yes, select medications tried:
 Aimovig Emgality Other:
4. For a non-preferred agent: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication? Yes No
If yes, select medications tried:
 Aimovig Emgality Nurtec ODT Other:

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:

Date:

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