FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/
prior-authorization-forms/

Request for Prior Authorization
Select Preventative Migraine Treatments

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for select preventative migraine treatments. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred select preventative migraine agent. Payment will be considered under the following conditions:

1. **Patient has one of the following diagnoses:**
   - a. **Chronic Migraine, defined as:**
     - i. **≥ 15 headache days per month for a minimum of 3 months; and**
     - ii. **≥ 8 migraine headache days per month for a minimum of 3 months; or**
   - b. **Episodic Migraine, defined as:**
     - i. **4 to 14 migraine days per month for a minimum of 3 months; or**
   - c. **Episodic Cluster Headache, defined as:**
     - i. **Occurring with a frequency between one attack every other day and 8 attacks per day; and**
     - ii. **With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods of ≥ 3 months; and**
     - iii. **Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting < 3 months, for at least 1 year); and**
2. **Request adheres to all FDA approved labeling for indication, including age, dosing, contraindications, warnings and precautions; and**
3. **The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and**
4. **Patient has been evaluated for and does not have medication overuse headache; and**
5. **For Episodic and Chronic Migraine, patient has documentation of three trials and therapy failures, of at least three months per agent, at a maximally tolerated dose with a minimum of two different migraine prophylaxis drug classes (i.e., anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]; or**
6. **For Episodic Cluster Headache, patient has documentation of:**
   - a. **A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and**

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b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy.

7. Lost, stolen, or destroyed medication replacement requests will not be authorized.

Initial requests will be approved for three months. Additional prior authorizations will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency).

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred
☐ Aimovig ☐ Ajovy

Non-Preferred
☐ Emgality ☐ Nurtec ODT ☐ Qulipta

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

☐ **Chronic Migraine (must document each criterion below):**

1. Patient has ≥ 15 headache days per month for a minimum of 3 months
   Number of headache days each month:

   Month 1: _____ Month 2: _____ Month 3: _____

2. Patient has ≥ 8 migraine headache days per month for a minimum of 3 months
   Number of migraine headache days each month:
   Month 1: _____ Month 2: _____ Month 3: _____

☐ **Episodic Migraine:**

1. Patient has 4 to 14 migraine headache days per month for a minimum of 3 months
   Number of migraine headache days each month:
   Month 1: _____ Month 2: _____ Month 3: _____

Chronic or Episodic Migraine treatment failures:

Trial 1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Trial 2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

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Trial 3: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

☐ **Episodic Cluster Headache (must document each criterion below):**

1. Occurs with a frequency between one attack every other day and 8 attacks per day:
   Frequency: _____:
2. Patient has at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods of ≥ 3 months:

   # of cluster periods: _____Length of cluster periods:_____

   Does patient have pain-free remission periods? ☐ Yes ☐ No

   If yes, length of pain-free remission periods: _____
3. Does patient have chronic cluster headache? ☐ Yes ☐ No

Episodic Cluster Headache treatment failures:

Glucocorticoid Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Verapamil Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Has patient been evaluated and medication overuse headache ruled out? ☐ Yes ☐ No

Is requested agent being used in combination with another CGRP inhibitor for the preventative treatment of migraine? ☐ Yes ☐ No

☐ **Requests for Non-Preferred Agents:** Document trial of a select preventative migraine agent

Name/Dose: _____ Trial Dates: _____

Failure reason: _____

☐ **Renewal Requests:** Document clinical response to therapy:_____

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For chronic or episodic migraine: number of headache/migraine days per month since start of therapy:

_____

For episodic cluster headache: number of cluster periods since start of therapy: _____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*