# PRIOR AUTHORIZATION REQUEST FORM

**EOC ID:**

Virginia Premier Anti Migraine Prior Authorization

**Phone:**
**Medallion 855-872-0005** **Fax back to: 866-754-9616**
**VPEPLUS 844-838-0711**

EnvisionRx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

| **Patient Name:** | **Prescriber Name:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Group Number: | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | Specialty/facility name (if applicable): | |

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For continuing therapy, please specify start date (MM/YY): If the request is for continuing therapy and the requested medication was approved by a previous Health Plan, please submit documentation of the previous approval to be considered.

Q3. Has patient had a clinical trial and failure, intolerance, or contraindication to preferred alternative Emgality?

☐ Yes ☐ No

Q4. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria?

☐ Yes ☐ No

Q5. Is the patient 18 years old or older?

☐ Yes ☐ No

Q6. The patient does not have medication overuse headache (MOH)?

☐ Yes ☐ No

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Q7. Women of childbearing age have had a pregnancy test at baseline?

☐ Yes ☐ No ☐ Not Applicable

Q8. Has member had greater than or equal to 4 migraine days per month for at least 3 months?

☐ Yes ☐ No

Q9. Is member utilizing prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, or life-style modifications)?

☐ Yes ☐ No

Q10. Please indicate if the member has had a trial and failure of at least 1 month of any of the following oral medications (select all that apply):

☐ Antidepressants (e.g. amitriptyline, venlafaxine)
☐ Beta blockers (e.g. propranolol, metoprolol, timolol, atenolol)
☐ Anti-epileptics (e.g. valproate, topiramate)
☐ Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g. lisinopril, candesartan)
☐ None of the above

Q11. For renewal, has member demonstrated a significant decrease in the number, frequency, and/or intensity of headaches?

☐ Yes ☐ No

Q12. For renewal, has member had an overall improvement in function with therapy?

☐ Yes ☐ No

Q13. For renewal, does the member continue to utilize prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)?

☐ Yes ☐ No

Q14. For renewal, If member is a woman of childbearing age, has she continued to be monitored for pregnancy status?

☐ Yes ☐ No

Q15. For renewal, has patient had an absence of unacceptable toxicity (e.g. intolerable injection site pain or constipation)?

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☐ Yes ☐ No

Prescriber Signature

Date