PRIOR AUTHORIZATION REQUEST FORM

Virginia Premier Anti-Migraine Non-Preferred

Phone: 800-727-7536 **Fax back to: 833-770-7569**

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 provide the start date (MM/YY):

Q3. For preventative treatment of migraine Emgality pen and syringe (120mg) and Ajovy Autoinjector are preferred products. For acute treatment of migraine Nurtec ODT is the preferred product. Please identify which of the preferred agents has been tried and failed

☐ Emgality pen or syringe (120 mg)
☐ Ajovy autoinjector
☐ Nurtec ODT
☐ No preferred products have been tried and failed

Q4. If none of the preferred products have been tried and failed please identify why the preferred agents cannot be used

Q5. Does the member have a diagnosis of migraine with or without aura base on International Classification of Headache Disorders (ICHD-III) diagnostic criteria?

☐ Yes ☐ No

Q6. For which of the following is the member using this medication? Check all that apply.

☐ Preventative treatment of migraine

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☐ Acute treatment of migraine
☐ Treatment of episodic cluster headache
☐ Other use

Q7. For OTHER USE, specify details:

Q8. Is the member 18 years of age or older?

☐ Yes ☐ No

Q9. Can you confirm that the member does not have medication over-use headache (MOH)?

☐ Yes ☐ No

Q10. If the member is a woman of childbearing age, has the member had a pregnancy test at baseline?

☐ Yes ☐ No ☐ Not applicable

Q11. Has the member experienced greater than or equal to 4 migraine days per month for at least 3 months?

☐ Yes ☐ No

Q12. Is the member is utilizing prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, or life-style modifications)?

☐ Yes ☐ No

Q13. Has the member tried and failed a greater than or equal to 1 month trial of any 2 of the following oral medications?

☐ 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)

Q14. For RENEWAL, did the member demonstrated significant decrease in the number, frequency, and/or intensity of headaches?

☐ Yes ☐ No

Q15. For RENEWAL, has the member experienced an overall improvement in function with therapy?

☐ Yes ☐ No

Q16. For RENEWAL, does the member continue to utilize prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, life-style modification)?

☐ Yes ☐ No

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Q17. For RENEWAL, if the member is a woman of childbearing age, will the member continue to be monitored for pregnancy status?

☐ Yes ☐ No ☐ Not applicable

Q18. For RENEWAL, does the member have an absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation)?

☐ Yes ☐ No

Prescriber Signature

Date