

**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
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>		
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 requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; 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 two trials and therapy failures, of at least three months per agent, at a maximally tolerated dose with 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

Emgality

**Non-Preferred**

Nurtec ODT

Qulipta

**Strength**

**Dosage Instructions**

**Quantity**

**Days Supply**

\_\_\_\_\_

**Diagnosis:**

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

- 1. Patient has  $\geq 15$  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  $\geq 8$  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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**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  $\geq 3$  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
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***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 Health and Human Services, that the member continues to be eligible for Medicaid.