

Request for Prior Authorization Select Preventative Migraine Treatments

FAX Completed Form To 1 (800) 574-2515 Provider Help Desk 1 (877) 776-1567

(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 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 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
 - 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.
- 6. 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.

470-5554 (Rev 4/25) Page 1 of 3

Request for Prior Authorization Select Preventative Migraine **Treatments**(PLEASE PRINT – ACCURACY IS IMPORTANT)

<u>Preferred</u>			Non-Preferi	<u>red</u>			
Aimovig	Ajovy	☐ Emgality	☐ Nurtec O	TC	☐ Qulipta		
	Strength	Dosage Instru	ctions	Qua	antity	Days Supply	
<u>Diagnosis:</u>							
☐ Chronic N	ligraine						
Has patient of	experienced ≥ 15	headache days p	per month for	a mir	nimum of 3 r	months?	
Has patient experienced ≥ 8 migraine headache days per month for a minimum of 3 months? ☐ Yes ☐ No							
☐ Episodic I	Migraine:						
	experienced 4 to	14 migraine heac	lache days pe	r mo	nth for a mi	nimum of 3 months?	
Episodic (Cluster Headach	e (must documen	t each criterio	n be	low):		
Do cluster h day? \(\square\) Ye	_	with a frequency	between one	attac	k every othe	er day and 8 attacks per	
Has patient experienced at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods of ≥ 3 months? ☐ Yes ☐ No							
Does patient have chronic cluster headache? Yes No							
Episodic Clu	ıster Headache tı	eatment failures:					
Glucocortico	oid Trial: Name/D)ose:			T	rial Dates:	
Failure reaso	n:						
Verapamil Tr	rial: Name/Dose:				т	rial Dates:	
Failure reaso	n:						
Has patient I	been evaluated a	nd medication ov	eruse headac	he ru	ıled out? 🗌	Yes 🗌 No	
	agent being use		with another	CGR	P inhibitor f	or the preventative	

470-5554 (Rev 4/25) Page 2 of 3

Request for Prior Authorization Select Preventative Migraine Treatments

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Requests for Non-Preferred Agents: Document trial of a select preventative migraine agent									
Nam	e/Dose:	Trial Dates:							
Failu	re reason:								
	Renewal Requests: Document clinical response to therapy:								
Poss	ible drug interactions/conflicting drug therapies:								
Attach	lab results and other documentation as necessary.								
Prescr	iber 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 Health and Human Services, that the member continues to be eligible for Medicaid.

470-5554 (Rev 4/25) Page 3 of 3