



**NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Migraine Calcitonin Agents: Aimovig/Ajovy/Emgality/Vyepti**

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

Clinical Information

1. Is the beneficiary 18 years old or older? Yes No
2. Is the beneficiary a woman of childbearing age? Yes No
2b. Has the beneficiary had a negative pregnancy test at baseline? Yes No
3. Does the beneficiary have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? Yes No
4. Does the beneficiary have a diagnosis of episodic cluster headache? Yes No
5. For non-preferred medications, has the beneficiary tried and failed 2 preferred medications in this class? Yes No
5b. Please list t/f medications or contraindications to the preferred medications: _____

Initial authorization for treatment of Migraines (Please answer questions 1-10) **Initial requests can be approved for up to 3-months for Aimovig, Emgality, Ajovy and Vyepti for monthly dosing or up to 6 months for Ajovy quarterly dosing:**

6. Does the beneficiary have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? Yes No
7. Does the beneficiary have medication over-use headache (MOH)? Yes No
8. Has the beneficiary experienced 4 or more migraine days per month for at least 3 months? Yes No
9. Is the beneficiary utilizing prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)?
 Yes No
10. Has the beneficiary tried and failed at least a month or greater trial of medications from at least 2 different classes from the following list of oral medications: 1. Antidepressants (e.g. amitriptyline, venlafaxine) 2. Beta Blockers (e.g. propranolol, metoprolol, timolol, atenolol) 3. Anti-epileptics (e.g. valproate, topiramate) 4. Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g. lisinopril, candesartan) 5. Calcium Channel Blockers (e.g. verapamil, nimodipine)? Yes No
Please list medications tried: _____

Initial authorization for treatment of Episodic Cluster Headache in Adults (Emgality 100mg/ml)(please answer questions 1-4 and 11-13) **Initial requests can be approved for up to 3-months:**

11. Has the beneficiary experienced 2 cluster periods lasting from 7 days to 1 year (when treated) and separated by pain-free remission periods of at least 3 months? Yes No
12. Is the beneficiary utilizing prophylactic intervention modalities (e.g. medication therapy)? Yes No
13. Is the beneficiary receiving no more than 300mg (administered as three consecutive injections of 100mg each) at the onset of the cluster headache period and then monthly until the end of the cluster headache period? Yes No

For re-authorization for all diagnosis (please answer questions 1-4 and 14-18) **Re-authorization requests can be approved for up to 12 months:**

14. Has the beneficiary experienced a significant decrease in the number, frequency, and/or intensity of headaches and/or decrease in the length of the cluster period? Yes No
15. Has the beneficiary experienced an overall improvement in function with therapy? Yes No
16. Does the beneficiary continue to utilize prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)? Yes No
17. If the beneficiary is a woman of childbearing age, is the provider continuing to monitor for pregnancy status? Yes No
18. Is the beneficiary experiencing unacceptable toxicity (e.g. intolerable injection site pain, constipation)? Yes No

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.