# Anti-Migraine, Other Agents: CGRP Antagonists, 5-HT1F Receptor Agonists Clinical Prior Authorization (PA) Request Form
# CT Medical Assistance Program
## To Be Completed By Prescriber

| Prescriber Information | Patient Information |
|---|---|
| Prescriber's NPI: | Patient's Medicaid ID Number: |
| Prescriber Name: | Patient Name: |
| Prescriber Subspecialty: | Patient Date of Birth: |
| Phone ( ) | Patient Current Weight: |
| Fax ( ) | Patient Primary ICD Diagnosis Code: |
| **Prescription Information** | |
| Drug, Strength, and Dosage Form Requested: | Frequency of Dosing: |
| □ New therapy □ Continuation | Quantity Requested: |

| Preferred Agents: | Non-Preferred Agents: |
|---|---|
| AJOVY AUTOINJECTOR, SYRINGE | AIMOVIG AUTOINJECTOR |
| EMGALITY **120** MG PEN, SYRINGE | EMGALITY **100** MG SYRINGE |
| NURTEC ODT TABLET | REYVOW TABLET |
| QULIPTA TABLET | VYEPTI VIAL |
| UBRELVY TABLET | ZAVZPRET NASAL SPRAY |

## Clinical Information

(attach supporting documentation, **required**)

***Note: Using samples to initiate therapy does not meet authorization requirements***

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|---|---|
| **1. For the Preventative Treatment of Migraine – Must meet the following:**<br>• Request is for either AIMOVIG or VYEPTI **AND**<br>• Patient has trialed and failed ONE of the following preferred Preventative Agents (Ajovy, Emgality 120mg, Nurtec ODT (preventative every other day dosing) or Qulipta) for minimum 30 days OR documented Adverse Reaction/Adverse Event or Contraindication to ALL preferred preventative agents:<br>o Preferred agent trialed: _____ | □ Yes □ No |

| | |
|---|---|
| ○ Trial Dates: _____<br>○ Reason for Failure: _____<br>○ If Adverse Reaction, Adverse Event, or Contraindication, please specify details:_____<br>_____ | |
| **2. For the Acute Treatment of Migraine – Must meet the following:**<br>• Request is for REYVOW or ZAVZPRET **AND**<br>• Patient has trialed and failed ONE preferred Acute Agent (Nurtec ODT,or Ubrelvy) for a minimum of 30 days OR documented Adverse Reaction/Adverse Event or Contraindication to ALL preferred acute agents:<br>○ Preferred agent trialed: _____<br>○ Trial Dates: _____<br>○ Reason for Failure: _____<br>○ If Adverse Reaction, Adverse Event, or Contraindication, please specify details:_____<br>_____ | □ Yes □ No |
| **3. For the Treatment of Episodic Cluster Headache – Must meet the following:**<br>• Request is for EMGALITY 100 MG SYRINGE **AND**<br>• Patient has trialed and failed ONE standard Prophylactic Agent OR has Contraindications to standard prophylactic therapy:<br>○ Preferred agent trialed: _____<br>○ Trial Dates: _____<br>○ Reason for Failure: _____<br>○ If Adverse Reaction, Adverse Event, or Contraindication, please specify details:_____<br>_____ | □ Yes □ No |

## For Initial Approval:
## Medication Requested and Documented diagnosis of ONE of the following:

(attach supporting documentation, **required**)

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|---|---|
| **Aimovig (erenumab-aooe) (18+ years of age):** | □ Yes □ No |

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| • Patient has a documented diagnosis of Chronic or Episodic Migraine Headaches with 4 or more migraine days per month **AND**<br>• Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred preventative treatment agent (as outlined above in Question 1 of Clinical Information section)<br>*Note: Quantity limited to 1 pen per 28 days* | |
| **Emgality 100 mg (galcanezumab-gnlm) (18+ years of age):**<br>• Patient has a documented diagnosis of Episodic Cluster Headache defined as 2 cluster headache attacks occurring in periods lasting from 7 days to one year, separated by pain-free periods lasting at least 3 months **AND**<br>• Failure to achieve the desired therapeutic outcome following a trial of at least ONE standard prophylactic agent OR has contraindications to standard prophylactic therapy (as outlined above in Question 3 of Clinical Information section)<br>*Note: Quantity limited to 3 syringes (1 carton) per 28 days* | □ Yes □ No |
| **Reyvow (lasmiditan) (18+ years of age):**<br>• Patient has a documented diagnosis of migraine headaches **AND**<br>• Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred acute treatment agent (as outlined above in Question 2 of Clinical Information section) **AND**<br>• Provider attests to advising patient not to drive or operate machinery until at least 8 hours after taking each dose of Reyvow | □ Yes □ No |
| **Vyepti (eptinezumab) (18+ years of age):**<br>• Patient has a documented diagnosis of Chronic or Episodic Migraine Headaches with 4 or more migraine days per month **AND**<br>• Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred preventative treatment agent (as outlined in Question 1 of Clinical Information section)<br>*Note: Quantity limited to 3 vials per 84 days* | □ Yes □ No |
| **Zavzpret (zavegepant) (18+ years of age):**<br>• Patient has a documented diagnosis of migraine headaches **AND**<br>• Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred acute treatment agent (as outlined above in Question 2 of Clinical Information section)<br>*Note: Quantity limited to 6 units (1 carton) per 22 days* | □ Yes □ No |

# Renewal Information

(attach supporting documentation, **required**)

***Note: Using samples to initiate therapy does not meet renewal authorization requirements***

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|---|---|
| • Has the patient previously met the required criteria set forth in Initial Approval Section above?<br>o Previous Approved Prior Authorization Number: _____<br>o Approval Dates: _____ | □ Yes □ No |
| • Patients' clinical response to treatment and ongoing safety has been monitored | □ Yes □ No |
| • Prescribers attest to the need for continued therapy and patient is compliant on current regimen | □ Yes □ No |

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.
I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

**Prescriber Signature*:_____Date:_____**

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**