CGRP Antagonists

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(ALL the following criteria must be met)*

- ☐ Patient is 18 years or older.
- ☐ Diagnosis of one of the following, per Headache Guidelines (https://www.ihs-headache.org/ichd-guidelines):
  - ☐ Chronic Migraine
  - ☐ Episodic Migraine
  - ☐ Episodic Cluster Headache, for Emgality only.

Chronic Migraine Prophylaxis Additional Criteria:

❑ Appropriate trial and failure of one agent from 3 of the 4 following drug classes:

Medication/Dose **(only those FDA-approved or compendia-recommended for migraine prophylaxis):** *Trial must be at maximum dose*	**Details of Trial and Failure** *Trial must be minimum of two months*	**Chart Note Page #**
Botulinum toxin: Dose:		
Beta-blocker: Dose:		

Anti-convulsant Dose:		
Antidepressant or Venlafaxine: Dose:		

☐ For concurrent therapy with Botox: The patient is still experiencing ≥4 migraine days per month while receiving Botox for chronic migraine prophylaxis.

Acute Migraine <u>Abortive</u> Treatment Additional Criteria:

❑ Trial and failure or contraindication to 2 triptans:

Medication/Dose	**Details of Trial and Failure** *Including Duration*	**Chart Note Page #**
Triptan: Dose:		
Triptan: Dose:		

Episodic Cluster Headache Treatment Additional Criterion (Emgality only):

❑ Trial and failure of Verapamil. Details: _____ Chart Note Page #: _____

Medication/Dose	**Details of Trial and Failure** *Including Duration*	**Chart Note Page #**
Verapamil Dose:		

Non-Preferred CGRP Product: *(Criteria above must also be met)*

❑ Trial and failure of preferred CGRP within same Utah Medicaid PDL class, or prescriber must demonstrate medical necessity for non-preferred product.

Medication/Dose	**Details**	**Chart Note Page #**
Preferred CGRP: Dose:		

Quantity Limits: Ubrelvy (ubrogepant): Max of 16 tablets per 30 days. **Nurtec** (rimegepant): Max of 8 tablets per 30 days (abortive treatment), 16 tablets per 30 days (prophylactic treatment)

Re-authorization Criteria: Updated letter of medical necessity or updated chart notes demonstrating positive clinical response with improvement in headache frequency (prophylaxis) or severity (abortive treatment).
Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date