OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692** . No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested – check applicable drug below:	
❑ **Aimovig®** (erenumab-aooe) Injection	❑ **Ajovy®** (fremanezumab-vfrm) Injection

DRUG INFORMATION: Complete information below or authorization will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Recommended dosage (for subcutaneous use only):

Aimovig® Dosage: 70 mg once a month; some patients may benefit from 140 mg once a month (given as 2 consecutive 70 mg injections). **Quantity Limit:** 1 autoinjector/30 days; 2 autoinjectors/30days; 2 prefilled syringes/ 30 days

Ajovy™ Dosage: 225 mg monthly or 675 mg quarterly dosage administered as 3 consecutive injections of 225 mg each; single-dose prefilled syringe – 225 mg/1.5mL solution

CLINICAL CRITERIA: All criteria **MUST** be met. **ALL** boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed.

Initial Approval – Three (3) months:

Does the member meet the following criteria?

1. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria? ❑ Yes ❑ No

AND

2. Is the member 18 years or older? ❑ Yes ❑ No

AND

3. The member does not have medication over-use headache (MOH). ❑ Yes ❑ No

AND

4. Women of childbearing age have had a pregnancy test at baseline. ❑ Yes ❑ No

(Continued on next page)

AND

5. Member has ≥ 4 migraine days per month for at least 3 months? ❑ Yes ❑ No

AND

6. Member is utilizing prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, or life-style modifications). ❑ Yes ❑ No

AND

7. Member has tried and failed a ≥ 1 month trial of any **TWO (2)** of the **following** oral medications: ❑ Yes ❑ No

- Antidepressants (e.g., amitriptyline, venlafaxine)
- Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
- Anti-epileptics (e.g., valproate, topiramate)
- Angiotensin converting inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan)

Renewal Approval – Twelve (12) months: All criteria **MUST** be completed to ensure authorization will be **NOT** delayed.

8. Did the member demonstrate significant decrease in the number, frequency, and/or intensity of headaches? ❑ Yes ❑ No

AND

9. Does the member have an overall improvement in function with therapy? ❑ Yes ❑ No

AND

10. Does the member continue to utilize prophylactic intervention modalities **(e.g., behavioral therapy, physical therapy, life-style modification)**? ❑ Yes ❑ No

AND

11. Women of childbearing age continue to be monitored for pregnancy status. ❑ Yes ❑ No

AND

12. Absence of unacceptable toxicity **(e.g., intolerable injection site pain or constipation)**. ❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy - PropriumRx

(Continued on next page; signature page MUST be attached to this request form.)

(Signature page MUST be included with request form)

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 7/19/2018
REVISED/UPDATED: ~~9/30/2018; 11/3//2018;;~~ **2/17/2019**;