# 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. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

## ANTIMIGRAINE DRUGS-OTHERS
## [Calcitonin Gene-Related Peptide (CGRP) Antagonists]

| **Drug Requested – check below drug that applies:** | |
|---|---|
| **PREFERRED Drugs (Require a prior authorization)** | |
| ❑ **Emgality®** (galcanezumab-gnlm) **Syringe** | ❑ **Emgality®** (galcanezumab-gnlm) **Pen** |
| **Non-Preferred Drugs** | |
| ❑ **Aimovig®** (erenumab-aooe) Injection | ❑ **Ajovy®** (fremanezumab-vfrm) Injection |

**DRUG INFORMATION:** Complete **all** 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):**

**Emgality® Dosage:** 240 mg loading dose (administered as 2 consecutive injections of 120 mg each), followed by monthly doses of 120 mg.

**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:** Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

**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**

**(Continued on next page)**

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

**AND**

3. 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

**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** boxes below **must** be checked to ensure authorization will be **NOT** delayed.

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

**AND**

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

**AND**

10. Does 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

**(Continued on next page; signature MUST be attached with this request.)**

***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; (Reformatted) 4/11/2019;~~ **6/19/2019**