OPTIMA HEALTH PLAN

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.**

Calcitonin Gene-Related Peptide (CGRP) Antagonists

Drug Requested: Aimovig®(erenumab)

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

Drug Form/Strength: _____

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

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

Recommended dose: (Aimovig®) Initial: 70 mg SC 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

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

Initial Authorization – 3 months (Chart notes **must** be submitted for documentation)

- ❑ Patient must be 18 years of age or older; **AND**
- ❑ The prescribing physician is a Neurologist, Headache Specialist **OR** has consulted with a Headache Specialist; **AND**

Diagnosis - check diagnosis below that applies:

- ❑ **Episodic Migraine**:
  - ❑ Patient must have a diagnosis of episodic migraines defined by **BOTH** of the following:
    - ❑ Patient has < 15 headache days per month **AND** 4 to 14 migraine days per month for a **minimum of 3 months**; **AND**
    - ❑ Patient must have failed a **3-month** trial of at least **TWO** migraine prophylactic classes supported from The American Headache Society/American Academy of Neurology treatment guidelines:
      - ❑ One of the following anticonvulsants: divalproex, valproate, topiramate
      - ❑ One of the following beta blockers: atenolol, metoprolol, nadolol, propranolol, timolol
      - ❑ One of the following antidepressants: amitriptyline, venlafaxine

OR

- ❑ **Chronic Migraine:**
  - ❑ Patient must have a diagnosis of chronic migraines defined by **BOTH** of the following:
    - ❑ Patient has ≥ 15 headache days per month AND > 8 migraine days per month for a **minimum of 3 months**; **AND**

(continued on next page)

- ❑ Patient must have failed a **3-month** trial of at least **TWO** migraine prophylactic classes supported from The American Headache Society/American Academy of Neurology treatment guidelines:
  - ❑ One of the following: anticonvulsants (divalproex, valproate, topiramate)
  - ❑ One of the following: beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
  - ❑ One of the following: antidepressants (amitriptyline, venlafaxine); **AND**
  - ❑ The patient has not received botulinum toxin injection for headache prophylaxis in the **past 4 months** **AND**
  - ❑ The patient will not be initiating botulinum toxin headache prophylaxis after starting the requested agent

****CGRP antagonist will not be approved for use in conjunction with Botox for headache prophylaxis.****

Reauthorization - 12 months (Chart notes must be submitted for documentation)

- ❑ The prescribing physician is a Neurologist, Headache Specialist **OR** has consulted with a Headache Specialist; **AND**
- ❑ Patient must have a reduction of 2 or more migraines per month **OR** reduced use of acute abortive migraine medications **(Chart notes must document improvement)** **AND**
- ❑ The patient has not received botulinum toxin injection for headache prophylaxis in the **past 4 months** **AND**
- ❑ The patient will not be initiating botulinum toxin headache prophylaxis after starting the requested agent

Medication being provided by a Specialty Pharmacy - PropriumRx

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