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. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Calcitonin Gene-Related Peptide (CGRP) Antagonists

Drug Requested: (Select one from below):

<table>
<thead>
<tr>
<th>PREFERRED</th>
<th>NON-PREFERRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Aimovig® (erenumab)</td>
<td>☐ Emgality® (galcanezumab)</td>
</tr>
<tr>
<td>☐ Ajovy® (fremanezumab)</td>
<td></td>
</tr>
</tbody>
</table>

*Member must have tried and failed BOTH preferred agents and meet all PA criteria for approval of Ajovy*

Optima Considers the use of concomitant therapy with Calcitonin Gene-Related Peptide Antagonists (CGRP) and Botox to be experimental and investigational. Safety and efficacy of these combinations has not been established and will not be permitted. In the event a member has an active Botox authorization on file, all subsequent CGRP requests will not be approved.

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

<table>
<thead>
<tr>
<th>Drug Form/Strength:</th>
<th>Dosing Schedule:</th>
<th>Length of Therapy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Dose Quantity Limit</td>
<td></td>
<td></td>
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<tr>
<th>Drug</th>
<th>Dose</th>
<th>Quantity Limit</th>
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<tbody>
<tr>
<td>Aimovig® (erenumab)</td>
<td>Initial: 70 mg SC once a month; some patients may benefit from 140 mg once a month (given as 2 consecutive 70 mg injections)</td>
<td>70mg/ml 2 pack; 2 auto-injectors/30 days; 70mg/ml prefilled syringe 2 syringes/30 days</td>
</tr>
<tr>
<td>Ajovy® (fremanezumab)</td>
<td>225 mg SC monthly or 675 mg every 3 months</td>
<td>225mg/1.5ml; 1.5ml (1 syringe) per 30 days or 4.5ml (3 syringes) per 90 days</td>
</tr>
<tr>
<td>Emgality® (galcanezumab)</td>
<td>Initial: 240 mg SC as a single loading dose, followed by 120 mg once monthly</td>
<td>120mg/ml; 1ml (1 auto-injector) per 30 days with one time loading dose of 2ml (2 auto-injectors)</td>
</tr>
</tbody>
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(Continued on next page)
**CLINICAL CRITERIA:** Check below **ALL** that apply. **ALL** criteria must be met for approval. **ALL** documentation including labs or chart notes (if required) must be submitted or request will be denied.

**Initial Authorization** – For initial 3 month approval, all of the following criteria must be met:

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

**DIAGNOSIS:** Please check one of the applicable diagnoses below

- **Episodic Migraine** (All applicable boxes below must be met to qualify)
  - 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 **2-month** trial of at least **TWO** migraine prophylactic classes supported by the American Headache Society/American Academy of Neurology treatment guidelines:
      - Anticonvulsants (divalproex, valproate, topiramate)
      - Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
      - Antidepressants (amitriptyline, venlafaxine)

- **Chronic Migraine** (All applicable boxes below must be met to qualify)
  - 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**
    - Patient must have failed a **2-month** trial of at least **TWO** migraine prophylactic classes supported by the American Headache Society/American Academy of Neurology treatment guidelines:
      - Anticonvulsants (divalproex, valproate, topiramate)
      - Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
      - Antidepressants (amitriptyline, venlafaxine);
    - **AND**
    - Patient has been evaluated for medication overuse headache (MOH) (defined as headaches occurring greater than or equal to 15 days per month. It develops as a consequence of regular overuse of acute or symptomatic headache medication for more than 3 months)
    - **AND**
Treatment will include a plan to taper off the offending medication if MOH is diagnosed;

**AND**

The patient will not be initiating botulinum toxin headache prophylaxis after starting the requested agent

**AND**

The requested medication will **NOT** be used in combination with Botox or another CGRP inhibitor or antagonist

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**Reauthorization – For 12 month reauthorization, all of the following criteria must be met:**

**-** The prescribing physician is a Neurologist or Pain Specialist **OR** has consulted with a Neurologist or Pain Specialist;

**AND**

**-** Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

**AND**

**-** Use of acute migraine medications (e.g., NSAIDs, triptans) has decreased since the start of CGRP inhibitor or antagonist therapy

**AND**

**-** The patient will not be initiating botulinum toxin headache prophylaxis after starting the requested agent

**AND**

**-** The patient continues to be monitored for medication overuse headache (MOH)

**AND**

**-** The requested medication will **NOT** be used in combination with Botox or another CGRP inhibitor or antagonist.

**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.*

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Patient Name: ____________________________________________ Date of Birth: ______________________

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: 3/14/2019, 7/1/2019