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):

PREFERRED	
❑ **Aimovig**® (erenumab)	❑ **Emgality**® (galcanezumab)
NON-PREFERRED	
❑ **Ajovy**® (fremanezumab)	

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

Drug Form/Strength: _____

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

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

Drug	Dose	Quantity Limit
Aimovig® (erenumab)	Initial: 70 mg SC once a month; some patients may benefit from 140 mg once a month (given as 2 consecutive 70 mg injections)	70mg/ml 2 pack; 2 auto-injectors/30 days; 70mg/ml prefilled syringe 2 syringes/30 days
Ajovy® (fremanezumab)	225 mg SC monthly **or** 675 mg every 3 months	225mg/1.5ml; 1.5ml (1 syringe) per 30 days or 4.5ml (3 syringes) per 90 days
Emgality® (galcanezumab)	Initial: 240 mg SC as a single loading dose, followed by 120 mg once monthly	120mg/ml; 1ml (1 auto-injector) per 30 days with one time loading dose of 2ml (2 auto-injectors)

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 – 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

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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 from 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 from 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 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.

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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: 2/28/2019