Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Emgality® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic migraines
❑ Episodic migraines
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the requested medication prescribed by or in consultation with a neurologist or pain specialist? ❑ **Yes** ❑ **No**

Select if the patient has failed a 2-month trial of the following migraine prophylactic classes supported from The American Headache Society/American Academy of Neurology treatment guidelines:

❑ Anticonvulsants (divalproex, valproate, topiramate)
❑ Antidepressants (amitriptyline, venlafaxine)
❑ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)

Chronic migraines, also answer the following:

Does the patient have ≥ 15 headache days per month AND > 8 migraine days per month for a minimum of 3 months? ❑ **Yes** ❑ **No**

Has the patient been evaluated for medication overuse headache (MOH) (defined as headaches occurring greater than or equal to 15 days per month, and develops as a consequence of regular overuse of acute or symptomatic headache medication for more than 3 months)? ❑ **Yes** ❑ **No**

Will the treatment include a plan to taper off the offending medication if MOH is diagnosed? ❑ **Yes** ❑ **No**

Will the patient be initiating botulinum toxin headache prophylaxis after starting the requested agent? ❑ **Yes** ❑ **No**

Episodic migraines, also answer the following:

Does the patient have < 15 headache days per month AND 4 to 14 migraine days per month for a minimum of 3 months? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Is the requested medication prescribed by or in consultation with a neurologist or pain specialist? ❑ **Yes** ❑ **No**

Has the patient experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity? ❑ **Yes** ❑ **No**

Has the use of acute migraine medications (e.g., NSAIDs, triptans) decreased since the start of CGRP inhibitor therapy? ❑ **Yes** ❑ **No**

Will the patient be initiating botulinum toxin headache prophylaxis after starting the requested agent? ❑ **Yes** ❑ **No**

Does the patient continue to be monitored for medication overuse headache (MOH)? ❑ **Yes** ❑ **No**

Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Emgality® Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Quantity limit requests:

What is the quantity requested per MONTH? _____

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____

_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

*** Please note: Chart documentation of the above is required to be submitted along with this fax*

_____

_____

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.