



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Aimovig™, Ajovy™, 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 <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
Select the diagnosis below: <input type="checkbox"/> Chronic migraines <input type="checkbox"/> Episodic migraines <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information: Is the requested medication prescribed by or in consultation with a neurologist or pain specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has had failure (after at least a 2 month trial) or intolerance to the following: <input type="checkbox"/> Botox (onabotulinum toxin A) [for chronic migraine only] <input type="checkbox"/> Depakote/Depakote ER (divalproex sodium) <input type="checkbox"/> Effexor (venlafaxine) <input type="checkbox"/> Effexor XR (venlafaxine ER) <input type="checkbox"/> Elavil (amitriptyline) <input type="checkbox"/> Topamax (topiramate) <input type="checkbox"/> One of the following beta blockers: atenolol, metoprolol, nadolol, propranolol, or timolol Select if the patient has contraindication to the following: <input type="checkbox"/> Botox (onabotulinum toxin A) [for chronic migraine only] <input type="checkbox"/> Depakote/Depakote ER (divalproex sodium) <input type="checkbox"/> Effexor (venlafaxine) <input type="checkbox"/> Effexor XR (venlafaxine ER) <input type="checkbox"/> Elavil (amitriptyline) <input type="checkbox"/> Topamax (topiramate) <input type="checkbox"/> ONE of the following beta blockers: atenolol, metoprolol, nadolol, propranolol, or timolol <input type="checkbox"/> ALL of the following beta blockers: atenolol, metoprolol, nadolol, propranolol, and timolol Will the requested medication be used in combination with another CGRP inhibitor or antagonist? <input type="checkbox"/> Yes <input type="checkbox"/> No For Ajovy requests, has the patient had a trial and failure, contraindication or intolerance to Aimovig AND Emgality? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For chronic migraines, also answer the following: Has medication overuse headache (MOH) been considered AND potentially offending medication(s) been discontinued? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have 15 or more headache days per month, of which at least 8 must be migraine days? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , has it been for at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Will the requested medication be used in combination with Botox (onabotulinum toxin A)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For episodic migraines, also answer the following: Does the patient have 4 to 14 migraine days per month (but no more than 14 headache days per month)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Aimovig-Ajovy-Emgality_Comm_2019Feb-W



Aimovig™, Ajovy™, Emgality™ Prior Authorization Request Form (Page 2 of 2)

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Reauthorization:

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

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

Will the requested medication be used in combination with another CGRP inhibitor or antagonist? Yes No

For chronic migraines, also answer the following:

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

Will the requested medication be used in combination with Botox (onabotulinum toxin A)? Yes No

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- Titration or loading dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- Other: _____

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.