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™ Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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:

Select if the requested medication was prescribed by or in consultation with the following specialist(s) having expertise in the treatment of the patient's diagnosis:

- ❑ Headache specialist
- ❑ Neurologist
- ❑ Pain specialist

Select if the patient has had a **trial and failure** (after at least a 2 month trial) or **intolerance** to the following:

- ❑ Botox (onabotulinum toxin A) [for chronic migraine only]
- ❑ Depakote/Depakote ER (divalproex sodium)
- ❑ Effexor (venlafaxine)
- ❑ Elavil (amitriptyline)
- ❑ Topamax (topiramate)
- ❑ One of the following beta blockers: atenolol, metoprolol, nadolol, propranolol, or timolol

Select if the patient has **contraindication** to the following:

- ❑ Botox (onabotulinum toxin A) [for chronic migraine only]
- ❑ Depakote/Depakote ER (divalproex sodium)
- ❑ Effexor (venlafaxine)
- ❑ Elavil (amitriptyline)
- ❑ Topamax (topiramate)
- ❑ **ONE** of the following beta blockers: atenolol, metoprolol, nadolol, propranolol, OR timolol
- ❑ **ALL** of the following beta blockers: atenolol, metoprolol, nadolol, propranolol, AND timolol

Please document all medications the patient has history of failure, contraindication, or intolerance to: _____

_____

Will the requested medication be used in combination with another CGRP antagonist or inhibitor? ❑ **Yes** ❑ **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.**

Aimovig™ Prior Authorization Request Form (Page 2 of 2)

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For chronic migraines, also answer the following:

Does the patient have 15 or more headache days per month? ❑ **Yes** ❑ **No**

Does the patient have 8 or more migraine days per month? ❑ **Yes** ❑ **No**

If yes to BOTH questions above**,** has it been for at least 3 months? ❑ **Yes** ❑ **No**

Has medication overuse headache (MOH) been considered AND potentially offending medication(s) have been discontinued? ❑ **Yes** ❑ **No**

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

For episodic migraines, also answer the following:

Does the patient have 4 to 14 migraine days per month? ❑ **Yes** ❑ **No**

Does the patient have less than 15 headache days per month? ❑ **Yes** ❑ **No**

Reauthorization:

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

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

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

Select if the requested medication was prescribed by or in consultation with the following specialist(s) having expertise in the treatment of the patient's diagnosis:

- ❑ Headache specialist
- ❑ Neurologist
- ❑ Pain specialist

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
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ 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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.

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