**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)

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

## 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 the medications the patient has a trial and failure, contraindication, or intolerance to (document the duration of trial):**

| | |
|---|---|
| ❑ Ajovy | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Amitriptyline (Elavil) | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Atenolol | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Divalproex delayed-release (Depakote) | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Divalproex extended-release [ER] (Depakote ER) | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Divalproex sodium | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Emgality | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Inderal XL | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ InnoPran XL | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Metoprolol | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Nadolol | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ OnabotulinumtoxinA (Botox) (for chronic migraine only) | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Propranolol | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Propranolol ER | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Timolol | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Topiramate (Topamax) | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Trokendi XR | ❑ 2 months trial or ❑ Other duration: _____ |
| ❑ Venlafaxine (Effexor) | ❑ 2 months trial or ❑ Other duration: _____ |

**For Aimovig 70mg/mL, also answer the following:**

Does the patient have a history of failure, contraindication, or intolerance to Aimovig 140mg/ml? ❑ **Yes** ❑ **No**

# 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**

**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:**

**If this is a reauthorization request, answer the following:**

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 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**

**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 1-844-403-1028.