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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

Ajovy™ & Emgality™ Prior Authorization Request Form (Page 1 of 2)

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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>					
Continuation of therapy: Is this request for a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
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: 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: <input type="checkbox"/> Headache specialist <input type="checkbox"/> Neurologist <input type="checkbox"/> Pain specialist Select if the patient has had a trial and 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"/> 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"/> Elavil (amitriptyline) <input type="checkbox"/> Topamax (topiramate) <input type="checkbox"/> One of the following beta blockers: atenolol, metoprolol, nadolol, propranolol, or timolol Does the patient have a trial and failure, contraindication, or intolerance to Aimovig? <input type="checkbox"/> Yes <input type="checkbox"/> No Please document all other 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? <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.**

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Ajovy™ & Emgality™ 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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