aetna™

Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Calcitonin Gene-Related Peptide Receptor Antagonists Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information						
☐ Aimovig	☐ Nurtec ODT	☐ Ubrelvy	☐ Ajovy	☐ Vyepti	☐ Emgality	☐ Vyepti
☐ Other, please specify:						

Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	ICD-10 Code:	Diagnosis:
What medication(s) have been tried and failed for diagnosis? (please specify):		

Are there any contraindications to formulary medications? (if yes, please specify)		☐ Yes	☐ No
☐ Renewal Request ONLY:	Was there clinical response to treatment by reduction in migraine OR headache days?	☐ Yes	☐ No
	Will medication be used in combination with another CGRP antagonist OR with Botox?	☐ Yes	☐ No
	☐ Aimovig 140mg: Was there trial and failure with Aimovig 70mg?	☐ Yes	☐ No
	☐ Vyepti 300mg: Was there trial and failure with Vyepti 100mg?	☐ Yes	☐ No

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information							
☐ Aimovig 140mg	Was there trial and failure with 70mg?	☐ Yes	☐ No	☐ Vyepti 300mg	Was there trial and failure with 100mg?	☐ Yes	☐ No
☐ Will medication requested be used with another CGRP antagonist OR Botox?		☐ Yes		☐ No			

☐ **Chronic Migraine**					
☐ **Aimovig**	☐ **Emgality**	☐ **Ajovy**	☐ **Vyepti**		
Are headaches occurring on FIFTEEN or more days per month with at least EIGHT migraine days per month for more than THREE months?				☐ Yes	☐ No
There is inadequate response OR intolerable side effect to at least THREE medications for migraine prophylaxis from TWO different classes, for at least THREE months (check all that apply):	☐ Beta-Blockers: propranolol, metoprolol, atenolol				
	☐ Anticonvulsants: Valproic acid, or divalproex, topiramate				
	☐ Antidepressants: Amitriptyline, venlafaxine				
	☐ ACE-Is/(ARBs: Lisinopril, candesartan, losartan, valsartan				
	☐ Calcium Channel Blockers: Diltiazem, nifedipine, nimodipine, verapamil				

☐ **Episodic Migraine**					
☐ **Aimovig**	☐ **Emgality**	☐ **Ajovy**	☐ **Vyepti**		
☐ Are headaches occurring on LESS THAN 15 days per month with 4 to 14 migraine days per month				☐ Yes	☐ No
There is inadequate response OR intolerable side effect to at least THREE medications for migraine prophylaxis from TWO different classes, for at least THREE months (check all that apply):	☐ Beta-Blockers: propranolol, metoprolol, atenolol				
	☐ Anticonvulsants: Valproic acid, or divalproex, topiramate				
	☐ Antidepressants: Amitriptyline, venlafaxine				
	☐ ACE-Is/(ARBs: Lisinopril, candesartan, losartan, valsartan				
	☐ Calcium Channel Blockers: Diltiazem, nifedipine, nimodipine, verapamil				

☐ **Episodic Cluster Headaches**						
☐ **Emgality**						
Are headaches occurring at maximum of EIGHT attacks per day OR minimum of ONE attack every other day?	☐ Yes	☐ No	Was there trial and failure with verapamil for PREVENTATIVE treatment OR sumatriptan (nasal or subcutaneous) for ACUTE treatment?		☐ Yes	☐ No

☐ **Acute Migraines**						
☐ **Ubrelvy**			☐ **Nurtec ODT**			
Will requested medication be used for moderate or severe pain intensity?	☐ Yes	☐ No	Is CrCl LESS THAN 15mL/min?		☐ Yes	☐ No
Is there documented inadequate response OR intolerable side effects with TWO triptans?	☐ Yes	☐ No	is there a contraindication to triptan use?		☐ Yes	☐ No
☐ **Ubrelvy**	Does member experience MORE THAN EIGHT migraine days per month?				☐ Yes	☐ No
☐ **Nurtec ODT**	Does member experience MORE THAN FIFTEEEN migraine days per month?				☐ Yes	☐ No
	Is there severe hepatic impairment (Child-Pugh class C)?				☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.