OKLAHOMA Health Care Authority

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State of Oklahoma
SoonerCare
Aimovig® (erenumab-aooe) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

Pharmacy billing (NDC:_____) Start Date (or date of next dose):_____

Dose: _____ Regimen:_____ Fill Quantity:_____ Day Supply:_____

Pharmacy Information

Pharmacy NPI:_____ Pharmacy Name:_____

Pharmacy Phone:_____ Pharmacy Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization (Initial approval will be for the duration of 3 months):

1. What is the member's diagnosis?
   - ☐ Preventive treatment of migraines in adults
   - ☐ Other, please list:_____
2. Does the member have documented:
   - ☐ Chronic Migraine Headache
   - ☐ Episodic Migraine Headache
3. Date of member's migraine diagnosis?_____
4. Number of headache days per month?_____
5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months): _____
6. Has the member been evaluated for all of the following, as defined by the American Headache Society, and these conditions have been ruled out and/or treated:
   a. Red flags? Yes☐ No☐
   b. Possible indicators of secondary headache? Yes☐ No☐
   c. Medication overuse? Yes☐ No☐
7. Will member use Aimovig® concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor? Yes☐ No☐
8. Has the member been counseled on appropriate use, administration technique, and storage of Aimovig®? Yes☐ No☐

For Continued Authorization:

1. Has the member been compliant with Aimovig® (erenumab-aooe) treatment? Yes☐ No☐
2. Has the member responded well to treatment with Aimovig® (erenumab-aooe)? Yes☐ No☐
3. Please provide the member's current number of migraine days per month:_____

Additional Information: _____

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

Fax completed prior authorization request form to 888-601-8461 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 AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*