

Ajovy[®] (fremanezumab-vfrm) 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):**

- What is the member's diagnosis?
 Preventive treatment of migraines in adults
 Other, please list: _____
- Does the member have documented:
 Chronic Migraine Headache
 Episodic Migraine Headache
- Date of member's migraine diagnosis? _____
- Number of headache days per month? _____
- Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months): _____
- 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:
 - Red flags? Yes ___ No ___
 - Possible indicators of secondary headache? Yes ___ No ___
 - Medication overuse? Yes ___ No ___
- Will member use Ajovy[®] concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor? Yes ___ No ___
- Has the member been counseled on appropriate use, administration technique, and storage of Ajovy[®]?
Yes ___ No ___

For Continued Authorization:

- Has the member been compliant with Ajovy[®] (fremanezumab-vfrm) treatment? Yes ___ No ___
- Has the member responded well to treatment with Ajovy[®] (fremanezumab-vfrm)? Yes ___ No ___
- 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.

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