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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

Antimigraine Agents, Others

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

Preventive treatment of migraine	
Preferred Agents *step edit required	**Non-Preferred Agents (PA required)**
Aimovig®, Ajovy® and Ajovy® autoinjector Emgality® pen and syringe (120 mg), Nurtec® ODT, Qulipta™	Emgality® syringe (100 mg), Vyepti ®
Acute treatment of migraine	
Preferred Agents (No PA with trial of 2 generic triptans)	**Non-Preferred Agents (PA required)**
Nurtec® ODT, Ubrelvy™	Reyvow®, Zavzpret™

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DRUG INFORMATION *(Continued)*

Identify why the preferred agents cannot be used.

DIAGNOSIS AND MEDICAL INFORMATION

All drugs in this class are eligible to receive a SIX (6)-month approval. Complete the following questions.

For Preventive treatment of migraine, does the member meet the *step edit AND the following criteria?

1. Has the prescriber assessed baseline disease severity utilizing an objective measure/tool (e.g., International Classification of Headache Disorders [ICHD-III], Headache Impact Test [HIT-6], monthly headache day [MHD], Migraine Disability Assessment [MIDAS], Migraine Physical Function Impact Diary [MPFID])? **AND**

   ☐ Yes ☐ No

2. Does the member meet the FDA indicated age for the requested product**? AND**

   ☐ Yes ☐ No

3. Has the member had ≥ 4 migraine days per month for at least 3 months? **AND**

   ☐ Yes ☐ No

4. *Has the member tried and failed a ≥ 1 month trial of any 2 of the following oral generic medications?
   - Antidepressants (e.g., amitriptyline, venlafaxine)
   - Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
   - Anti-epileptics (e.g., valproate, topiramate)
   - Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan)

   ☐ Yes ☐ No

5. For Nurtec and Qulipta, has the member tried and failed 1 of the preferred injectable agents?

   ☐ Yes ☐ No

For renewal, complete the following question to receive a TWELVE (12)-month approval.

1. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

For Acute treatment of migraine, does the member meet the *step edit AND the following criteria?

1. Does the member have a diagnosis of migraine with or without aura? **AND**

   ☐ Yes ☐ No

2. Is the member ≥ 18 years of age? **AND**

   ☐ Yes ☐ No

3. *Has the member tried and failed (or has contraindications to) two preferred triptan medications?

   ☐ Yes ☐ No

For renewal, complete the following question to receive a TWELVE (12)-month approval.

1. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

For Episodic Cluster Headache, does the member meet the following criteria?

1. Does the member have a diagnosis of episodic cluster headache? **AND**

   ☐ Yes ☐ No

2. Is the member ≥ 18 years of age? **AND**

   ☐ Yes ☐ No

3. Has the member experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months? **AND**

   ☐ Yes ☐ No

4. Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines? **AND**

   ☐ Yes ☐ No

5. Has the member tried and failed (or has contraindications to) at least one standard prophylactic (preventive) pharmacologic therapy for cluster headache?

   ☐ Yes ☐ No

For renewal, complete the following question to receive a TWELVE (12)-month approval.

1. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.