Iowa Department of Human Services

Request for Prior Authorization
CGRP Inhibitors

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for CGRP Inhibitors. Payment will be considered for patients when the following is met:

1. **Patient has a diagnosis of migraine as defined by one of the following:**
   a. **Chronic Migraine**
      i. **≥ 15 headache days per month for a minimum of 3 months; and**
      ii. **≥ 8 migraine headache days per month for a minimum of 3 months; or**
   b. **Episodic Migraine**
      i. **4 to 14 migraine days per month for a minimum of 3 months; and**
2. **Patient meets the FDA approved age; and**
3. **Patient has been evaluated for and does not have medication overuse headache; and**
4. **Patient has documentation of three trials and therapy failures, of at least three months per agent, at a maximally tolerated dose with a minimum of two different migraine prophylaxis drug classes (i.e., anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]; and**
5. **The requested dose does not exceed the maximum FDA labeled dose; and**
6. **Lost, stolen, or destroyed medication replacement requests will not be authorized.**

Initial requests will be approved for three months. Additional prior authorizations will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days).

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ Aimovig ☐ Ajovy ☐ Emgality

Strength	Dosage Instructions	Quantity	Days Supply

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☐ **Chronic Migraine (must document each criteria below):**
Patient has ≥ 15 headache days per month for a minimum of 3 months
Number of headache days per month:

Month 1: _____ Month 2: _____ Month 3: _____

Patient has ≥ 8 migraine headache days per month for a minimum of 3 months
Number of migraine headache days per month:

Month 1: _____ Month 2: _____ Month 3: _____

☐ **Episodic Migraine:**
Patient has 4 to 14 migraine headache days per month for a minimum of 3 months

Number of migraine headache days per month: _____ Duration (months): _____

Has patient been evaluated and medication overuse headache ruled out? ☐ Yes ☐ No

Treatment failures:

Trial 1: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Trial 2: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Trial 3: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

☐ **Renewal Requests:** Document clinical response to therapy:_____

_____

_____

Number of headache/migraine days per month since start of therapy:_____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*