

MIGRAINE PREVENTION AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/6/2025)



Keystone First

PERFORMSM
Next Generation Pharmacy Benefits

Fax to PerformRxSM at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	# of pages:	Name of office contact:
Contact's phone number:	LTC facility contact/phone:	

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID#:
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

CLINICAL INFORMATION

Product requested (clinical prior auth required):		
Preferred	Non-Preferred	
<input type="checkbox"/> Aimovig 70 mg/ml autoinjector <input type="checkbox"/> Aimovig 140 mg/ml autoinjector <input type="checkbox"/> Ajovy 225 mg/1.5 ml autoinjector <input type="checkbox"/> Ajovy 225 mg/1.5 ml syringe	<input type="checkbox"/> Emgality 120 mg/ml autoinjector <input type="checkbox"/> Emgality 120 mg/ml syringe <input type="checkbox"/> Emgality 300 mg (100 mg/ml syringe x 3) <input type="checkbox"/> Nurtec ODT 75 mg	
	<input type="checkbox"/> Qulipta Tablet 10 mg <input type="checkbox"/> Qulipta Tablet 30 mg <input type="checkbox"/> Qulipta Tablet 60 mg <input type="checkbox"/> Vyepti IV Solution 100 mg/ml <input type="checkbox"/> Other: _____	
Dose/directions	Quantity:	Refills:
Diagnosis (submit documentation):	DX code (required):	
Is the medication being prescribed by, or in consultation with, a neurologist or a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)? <input type="checkbox"/> Yes <i>Submit documentation of consultation, if applicable.</i> <input type="checkbox"/> No		

ALL INITIAL REQUESTS

- If the patient is currently using a Migraine Prevention Agent, one of the following:
☐ Will discontinue use of that Migraine Prevention Agent prior to starting the requested Migraine Prevention Agent
☐ Has a medical reason for concomitant use of both Migraine Prevention Agents that is supported by peer-reviewed literature or national treatment guidelines. Please explain:
- For a non-preferred agent: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication?
☐ Yes ☐ No
If yes, select medications tried:
☐ Aimovig ☐ Ajovy ☐ Emgality ☐ Nurtec ODT ☐ Other:

INITIAL REQUESTS FOR MIGRAINES

- Has the patient averaged 4 or more migraine days per month over the past 3 months? ☐ Yes ☐ No
- For gepant (e.g., Nurtec ODT, Qulipta): Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication?
☐ Yes ☐ No
If yes, select medications tried:
☐ Aimovig ☐ Ajovy ☐ Emgality ☐ Other:
- Does the patient have a confirmed diagnosis of migraine (with or without aura) according to the current International Headache Society Classification of Headache Disorders?
☐ Yes ☐ No
- Does the patient have a history of trial and failure of or contraindication or intolerance to at least one drug from one of the following three classes?
☐ anticonvulsants (e.g., divalproex, topiramate, valproic acid) ☐ antidepressants (e.g., amitriptyline, venlafaxine) ☐ beta blockers (e.g., metoprolol, propranolol, timolol)
☐ Yes - List medications tried:
☐ No
- Provide average number of migraine days and headache days per month at baseline:

MIGRAINE PREVENTION AGENTS PRIOR AUTHORIZATION FORM

INITIAL REQUESTS FOR EPISODIC CLUSTER HEADACHE	
1. Does the patient have confirmed diagnosis of episodic cluster headache according to the current International Headache Society Classification of Headache Disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Does the patient have a history of trial and failure, contraindication, or intolerance of a preventive medication recommended by current consensus guidelines for episodic cluster headaches? <input type="checkbox"/> Yes - <i>List medications tried:</i> <input type="checkbox"/> No	

RENEWAL REQUESTS	
1. For the prevention of migraine: Since starting the requested medication, did the patient experience one of the following: <input type="checkbox"/> Reduction in the average number of migraine days per month from baseline <input type="checkbox"/> Decrease in severity or duration of migraines from baseline	
2. For episodic cluster headache: Since starting the requested medication, did the patient experience a reduction in cluster headache frequency from baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. For gepant (e.g., Nurtec ODT, Qulipta), for the prevention of migraine: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, select medications tried: <input type="checkbox"/> Aimovig <input type="checkbox"/> Ajovy <input type="checkbox"/> Emgality <input type="checkbox"/> Other:	
4. For a non-preferred agent: Does the patient have history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for their indication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, select medications tried: <input type="checkbox"/> Aimovig <input type="checkbox"/> Ajovy <input type="checkbox"/> Emgality <input type="checkbox"/> Nurtec ODT <input type="checkbox"/> Other:	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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