# Nevada Medicaid

Submit fax request to: 855-455-3303
Please note: All information below is required to process this request.

## Calcitonin Gene-Related Peptide (CGRP) Receptor Inhibitor Medications Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select all that apply:**

**Episodic Migraines:**

- ❑ The recipient has a documented diagnosis of episodic migraines
- ❑ The recipient is 18 years of age or older
- ❑ The recipient has four to 14 migraine days per month, but no more than 14 headache days per month (for Nurtec® requests, the recipient does not have more than 18 headache days per month)
- ❑ No other CGRP Inhibitor will be used in combination
- ❑ If the request is for continuation of therapy, the recipient has all of the following:
  - A documented positive response to the requested agent, demonstrated by a reduction in headache frequency and/or intensity
  - A decrease in the use of acute migraine medications (e.g., NSAIDs, triptans)

Indicate which of the following have been tried and failed after a two-month trial or the recipient has a contraindication:

| | | |
|---|---|---|
| ❑ Amitriptyline | ❑ Venlafaxine | ❑ Divalproex |
| ❑ Topiramate | ❑ Atenolol | ❑ Propranolol |
| ❑ Nadolol | ❑ Timolol | ❑ Metoprolol |

**Chronic Migraines:**

- ❑ The recipient has a documented diagnosis of chronic migraines
- ❑ The recipient is 18 years of age or older
- ❑ The recipient has been evaluated for medication overuse headache (MOH)
- ❑ If the recipient has a diagnosis of MOH, then there will be a treatment plan that will include a taper of the offending medication
- ❑ The recipient has ≥ 15 headache days per month, of which at least eight must be migraine days for at least three months
- ❑ No other CGRP Inhibitor will be used in combination
- ❑ The medication will not be used in combination with Botox (onabotulinumtoxinA)
- ❑ If the request is for continuation of therapy, the recipient has all of the following:
  - A documented positive response to the requested agent, demonstrated by a reduction in headache frequency and/or intensity
  - A decrease in the use of acute migraine medications (e.g., NSAIDs, triptans)
  - Continued monitoring for MOH

Indicate which of the following have been tried and failed after a two-month trial or the recipient has a contraindication:

| | | |
|---|---|---|
| ❑ Amitriptyline | ❑ Venlafaxine | ❑ Divalproex |
| ❑ Topiramate | ❑ Atenolol | ❑ Propranolol |

## Clinical Information continued (required)

**Select all that apply:**

**Acute Migraines:**

- ❑ The recipient has a documented diagnosis of acute migraine with or without aura
- ❑ The recipient is 18 years of age or older
- ❑ The prescribed dose will not exceed two doses per migraine and treating no more than eight migraine episodes per 30 days
- ❑ The recipient has had at least one trial and failure of a triptan agent

  Document triptan agent: _____
- ❑ No other CGRP Inhibitor will be used in combination
- ❑ If the request is for continuation of therapy, the recipient had a documented positive response to therapy with the requested agent

**Episodic Cluster Headaches:**

- ❑ The recipient has a documented diagnosis of episodic cluster headache
- ❑ The recipient is 18 years of age or older
- ❑ The recipient has experienced at least two cluster periods lasting from seven days to 365 days, separated by pain-free periods lasting at least three months
- ❑ If the request is for continuation of therapy, the recipient had a documented positive response to therapy with the requested agent, demonstrated by a reduction in headache frequency and/or intensity

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.