

## 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

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|   | P   | Provider Information (required) |                    |                    |                        |                  |            |             |                   |  |
|---|---|---------------------------------|--------------------|--------------------|------------------------|------------------|------------|-------------|-------------------|--|
| Member Name:  |   |                                 |                    | Provider Nam       | Provider Name:         |                  |            |             |                   |  |
| Insurance ID#:  |   |                                 | NPI#:              |                    |                        |                  | Specialty: |             |                   |  |
| Date of Birth:  |   |                                 | Office Phone       | Office Phone:      |                        |                  |            |             |                   |  |
| Street Address:   |   |                                 |                    | Office Fax:        | Office Fax:            |                  |            |             |                   |  |
| City:   | ty: State: Zip:   |                                 |                    | Office Street      | Office Street Address: |                  |            |             |                   |  |
| Phone:  |   |                                 |                    | City:              |                        |                  | State      | e:          | Zip:              |  |
|   |   | M                               | edication l        | nformation (r      | rea                    | uired)           |            |             |                   |  |
| Medication Name:  |   |                                 |                    |                    | Strength: Dosage Form: |                  |            |             |                   |  |
|   |   |                                 |                    | _                  | rections for Use:      |                  |            |             |                   |  |
| Check   |   | 1                               |                    |                    |                        |                  |            |             |                   |  |
|   |   |                                 | Clinical Inf       | ormation (req      | quir                   | red)             |            |             |                   |  |
| Select all  | I that apply:   |                                 |                    |                    | •                      |                  |            |             |                   |  |
| Episo   | dic Migraines:  |                                 |                    |                    |                        |                  |            |             |                   |  |
| The recipient has a documented diagnosis of episodic migraines  |   |                                 |                    |                    |                        |                  |            |             |                   |  |
|   | <ul> <li>The recipient is 18 years of age or older</li> </ul>   |                                 |                    |                    |                        |                  |            |             |                   |  |
|   | <ul> <li>The recipient has four to 14 migraine days per month, but no more than 14 headache days per month (for Nurtec<sup>®</sup></li> </ul> |                                 |                    |                    |                        |                  |            |             |                   |  |
|   | 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 the requirier the registric the following:          |                                 |                    |                    |                        |                  |            |             |                   |  |
| 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        |                    | ב                      | Divalproex       |            |             |                   |  |
|   | Topiramate  |                                 | Atenolol           |                    | ב                      | Propranolol      |            |             |                   |  |
|   | Nadolol   |                                 | Timolol            |                    |                        | Metoprolol       |            |             |                   |  |
| Chroni  | ic Migraines:   |                                 |                    |                    |                        |                  |            |             |                   |  |
| The recipient has a documented diagnosis of chronic migraines   |   |                                 |                    |                    |                        |                  |            |             |                   |  |
|   | The recipient has a documented diagnosis of chronic migrames  |                                 |                    |                    |                        |                  |            |             |                   |  |
|   | The recipient has been evaluated for medication overuse headache (MOH)  |                                 |                    |                    |                        |                  |            |             |                   |  |
|   |   |                                 |                    |                    |                        |                  |            |             |                   |  |
|   |   |                                 |                    |                    |                        |                  |            |             |                   |  |
|   | medication $b_{1}$ The regiment has $> 15$ handrade days non-month of which at least eight must be migraine days for at least three           |                                 |                    |                    |                        |                  |            |             |                   |  |
|   | □ The recipient has $\geq$ 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   |   |                                 |                    |                    |                        |                  |            |             |                   |  |
| <ul> <li>A decrease in the use of acute migraine medications (e.g., NSAIDs, triptans)</li> </ul>                            |   |                                 |                    |                    |                        |                  |            |             |                   |  |
| •   | Continued monito  | ring for MOH                    |                    |                    |                        |                  |            |             |                   |  |
| Indic   | ate which of the fol  | lowing have bee                 | en tried and faile | ed after a two-mor | nth                    | n trial or the r | recipie    | ent has a d | contraindication: |  |
|   | Amitriptyline   |                                 |                    |                    |                        | <b>_</b>         | -          |             |                   |  |
|   |   |                                 | Atenolol           |                    |                        |                  |            |             |                   |  |
|   | - I   | _                               |                    |                    | _                      |                  |            |             |                   |  |

### 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 painfree 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?

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.

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