PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Aimovig

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. For what diagnosis is this drug being prescribed?

- ☐ Episodic migraines: 4 - 14 migraine days per month but no more than 14 headaches per month
- ☐ Chronic migraines: for at least 3 months, 15 headache days per month or more, of which at least 8 must be migraine days
- ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Specify the prescriber's specialty

☐ Neurology ☐ Pain ☐ Other

Q4. Is the patient a new start to therapy?

☐ Yes ☐ No - please specify start date

Q5. If the request is for the 140 mg dose, was the patient started on the 70 mg dose and had an inadequate response?

- ☐ Yes
- ☐ No

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☐ Not applicable - requesting 70 mg dose

Q6. If for chronic migraines, has an evaluation for medication overuse headaches (MOH) been completed?

☐ Yes
☐ No
☐ Not applicable - does not have chronic migraines

Q7. If the patient has MOH, does the treatment plan include tapering off the offending medication?

☐ Yes
☐ No
☐ Not applicable - does not have MOH

Q8. If the patient has MOH, is there documented ongoing monitoring of the MOH?

☐ Yes
☐ No
☐ Not applicable - does not have MOH

Q9. Does the patient have failure of an adequate trial (2 months or more) to the following Beta blockers? Please select all that apply.

☐ Atenolol
☐ Metoprolol
☐ Nadolol
☐ Propranolol
☐ Timolol
☐ Other (please specify)

Q10. Does the patient have contraindication to the following Beta blockers? Please select all that apply.

☐ Atenolol
☐ Metoprolol
☐ Nadolol
☐ Propranolol
☐ Timolol
☐ Other (please specify)

Q11. Does the patient have failure of an adequate trial (2 months or more) to the following antiepileptics? Please select all that apply.

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- ☐ Divalproex
- ☐ Sodium valproate
- ☐ Topiramate
- ☐ Other (please specify)

Q12. Does the patient have contraindication to the following antiepileptics? Please select all that apply.

- ☐ Divalproex
- ☐ Sodium valproate
- ☐ Topiramate
- ☐ Other (please specify)

Q13. Does the patient have failure of an adequate trial (2 months or more) to the following antidepressants? Please select all that apply.

- ☐ Amitriptyline
- ☐ Venlafaxine
- ☐ Other (please specify)

Q14. Does the patient have contraindication to the following antidepressants? Please select all that apply.

- ☐ Amitriptyline
- ☐ Venlafaxine
- ☐ Other (please specify)

Q15. Will Aimovig be used in combination with any of the following?

- ☐ Another CGRP inhibitor (please specify)
- ☐ Botox (onabotulinumtoxinA)
- ☐ None of the above

Q16. If for continuation of therapy, please specify all that apply:

- ☐ Reduction in headache frequency and/or intensity
- ☐ Decrease in use of acute medications (ex. NSAIDs, triptans) since starting Aimovig
- ☐ Other (please specify)

Q17. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group

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☐ Facility
☐ Other (please specify)

Q18. Provide name and NPI of the billing entity

Q19. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q20. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.