Aetna Better Health® of Virginia REQUEST FORM

Antimigraine Agents, Others

Fax back to 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

Preventive treatment of migraine	
Preferred Agents *step edit required	**Non-Preferred Agents (PA required)**
Aimovig®, Ajovy® and Ajovy® autoinjector Emgality® pen and syringe (120 mg), Nurtec® ODT	Emgality® syringe (100 mg) Qulipta™
Acute treatment of migraine	
Preferred Agents (No PA with trial of 2 generic triptans)	**Non-Preferred Agents (PA required)**
Nurtec® ODT, Ubrelvy™	Reyvow®, Trudhesa™

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DRUG INFORMATION *(Continued)*

Identify why the preferred agents cannot be used.

_____

DIAGNOSIS AND MEDICAL INFORMATION

All drugs in this class are eligible to receive a SIX (6)-month approval. Complete the following questions.

For Preventive treatment of migraine, does the member meet the *step edit AND the following criteria?

1. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria? **AND**

   ☐ Yes ☐ No

2. Is the member ≥ 18 years of age? **AND**

   ☐ Yes ☐ No

3. Has the member had ≥ 4 migraine days per month for at least 3 months? **AND**

   ☐ Yes ☐ No

4. *Has the member tried and failed a ≥ 1 month trial of any 2 of the following oral generic medications?

   - Antidepressants (e.g., amitriptyline, venlafaxine)
   - Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
   - Anti-epileptics (e.g., valproate, topiramate)
   - Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan)

   ☐ Yes ☐ No

For renewal, complete the following question to receive a TWELVE (12)-month approval.

1. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

For Acute treatment of migraine, does the member meet the *step edit AND the following criteria?

1. Does the member have a diagnosis of migraine with or without aura? **AND**

   ☐ Yes ☐ No

2. Is the member ≥ 18 years of age? **AND**

   ☐ Yes ☐ No

3. *Has the member tried and failed (or has contraindications to) two preferred triptan medications?

   ☐ Yes ☐ No

4. Prior to initiation of Trudhesa™, a cardiovascular evaluation is recommended. Has this been completed?

   ☐ Yes ☐ No

For renewal, complete the following question to receive a TWELVE (12)-month approval.

2. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

For Episodic Cluster Headache, does the member meet the the following criteria?

1. Does the member have a diagnosis of episodic cluster headache? **AND**

   ☐ Yes ☐ No

2. Is the member ≥ 18 years of age**? AND**

   ☐ Yes ☐ No

3. Has the member experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months? **AND**

   ☐ Yes ☐ No

4. Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines? **AND**

   ☐ Yes ☐ No

5. Has the member tried and failed (or has contraindications to) at least one standard prophylactic (preventive) pharmacologic therapy for cluster headache?

   ☐ Yes ☐ No

For renewal, complete the following question to receive a TWELVE (12)-month approval.

1. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.