NC Medicaid
Pharmacy Prior Approval Request for
Migraine Calcitonin Agents: Preventative-Aimovig/Ajovy/Emgality/Vyepti/Qulipta/Nurtec

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____
Address _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Initial authorization for PREVENTATIVE treatment of Migraines (INJECTABLES) (Aimovig, Ajovy, Emgality 120mg/ml, and Vyepti) **Initial requests can be approved for up to 3-months for Aimovig, Emgality, Ajovy, and Vyepti for monthly dosing or up to 6 months for Ajovy quarterly dosing**:**

1.. Does the beneficiary have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? ☐ **Yes** ☐ **No**
2. Is the beneficiary 18 years old or older? ☐ **Yes** ☐ **No**
3. Does the beneficiary have medication over-use headache (MOH)? ☐ **Yes** ☐ **No**
4. For beneficiaries that are women of childbearing age, is there a negative pregnancy test at baseline? ☐ **Yes** ☐ **No**
5. Has the beneficiary experienced 4 or more migraine days per month for at least 3 months? ☐ **Yes** ☐ **No**
6. Is the beneficiary utilizing prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)? ☐ **Yes** ☐ **No**
7. Has the beneficiary tried and failed at least a month or greater trial of medications from at least 2 different classes from the following list of oral medications: 1. Antidepressants (e.g. amitriptyline, venlafaxine) 2. Beta Blockers (e.g. propranolol, metoprolol, timolol, atenolol) 3. Anti-epileptics (e.g. valproate, topiramate) 4. Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g. lisinopril, candesartan) 5. Calcium Channel Blockers (e.g. verapamil, nimodipine)? ☐ **Yes** ☐ **No**
   Please list medications tried: _____

Initial authorization for PREVENTATIVE treatment of Migraines (ORALS) (Nurtec ODT, Qulipta) **Initial requests can be approved for up to 3-months

1. Does the beneficiary have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? ☐ **Yes** ☐ **No**
2. Is the beneficiary 18 years old or older? ☐ **Yes** ☐ **No**
3. Does the beneficiary have medication over-use headache (MOH)? ☐ **Yes** ☐ **No**
4. Has the beneficiary experienced 4 or more migraine days per month for at least 3 months? ☐ **Yes** ☐ **No**
5. Is the beneficiary utilizing prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)? ☐ **Yes** ☐ **No**
6. Has the beneficiary tried and failed at least 2 preferred injectable CGRPs? ☐ **Yes** ☐ **No**
7. **For Nurtec ONLY**
   7a. Will the Beneficiary use Nurtec concurrently with a strong CYP3A4 inhibitor? ☐ **Yes** ☐ **No**
   7b. Does the Beneficiary have end-stage renal disease with a creatinine clearance (CrCl) less than 15ml/min? ☐ **Yes** ☐ **No**

Initial authorization for treatment of Episodic Cluster Headache in Adults (Emgality 100mg/ml) **Initial requests can be approved for up to 3-months**:**

1. Does the beneficiary have a diagnosis of Episodic Cluster Headache? ☐ **Yes** ☐ **No**
2. Has the beneficiary experienced 2 cluster periods lasting from 7 days to 1 year (when treated) and separated by pain-free remission periods of at least 3 months? ☐ **Yes** ☐ **No**
3. Is the beneficiary 18 years old or older? ☐ **Yes** ☐ **No**
4. For beneficiaries that are women of childbearing age, is there a negative pregnancy test at baseline? ☐ **Yes** ☐ **No**
5. Is the beneficiary utilizing prophylactic intervention modalities (e.g. medication therapy)? ☐ **Yes** ☐ **No**
6. Is the beneficiary receiving no more than 300mg (administrated as three consecutive injections of 100mg each) at the onset of

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the cluster headache period and then monthly until the end of the cluster headache period? ☐ **Yes** ☐ **No**

For re-authorization for all diagnoses **Re-authorization requests can be approved for up to 12 months**:

1. Has the beneficiary experienced a significant decrease in the number, frequency, and/or intensity of headaches and/or decrease in the length of the cluster period? ☐ **Yes** ☐ **No**
2. Has the beneficiary experienced an overall improvement in function with therapy? ☐ **Yes** ☐ **No**
3. Does the beneficiary continue to utilize prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)? ☐ **Yes** ☐ **No**
4. If the beneficiary is a woman of childbearing age, is the provider continuing to monitor for pregnancy status? **(not required for Qulipta or Nurtec)** ☐ **Yes** ☐ **No**
5. Is the beneficiary experiencing unacceptable toxicity (e.g. intolerable injection site pain, constipation)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date:_____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.