CGRP Injection

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

Send completed form to: Priority Partners Fax: 1-866-212-4756

Site of Service Questions:

A. What drug is being requested?
- ❑ Ajovy, *skip to Clinical Criteria Questions*
- ❑ Vyepti

B. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital
- ❑ Off Campus Outpatient Hospital
- ❑ Home based setting, *skip to Criteria Questions*
- ❑ Community office, *skip to Criteria Questions*
- ❑ Ambulatory infusion site, *skip to Criteria Questions*

C. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

D. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

I. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

1. What is the ICD-10 code? _____
2. Is the requested drug being prescribed for the preventive treatment of migraine in an adult patient? ❑ Yes ❑ No
3. Will the requested drug be used concurrently with another CGRP receptor antagonist? ❑ Yes ❑ No
4. Has the patient received at least 3 months of treatment with the requested drug? ❑ Yes ❑ No *If No, skip to #7*
5. Has the patient had a reduction in migraine days per month from baseline? ❑ Yes ❑ No
6. Does the patient require more than the plan allowance of any of the following:
   a) 1 injection of 140mg or 2 injections of 70mg per month of Aimovig,

b) 3 injections (225mg each) per 3 months of Ajovy,
c) 1 injection (120mg) per month of Emgality,
d) 3 single dose vials (100mg each) for intravenous infusion per 3 months of Vyepti?
❑ Yes ❑ No *No further questions*

7. Has the patient experienced an inadequate treatment response with an 8-week trial of any of the following: A) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), B) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), C) Antidepressants (e.g., amitriptyline, venlafaxine)? *If Yes, skip to #9* ❑ Yes ❑ No

8. Has the patient experienced an intolerance to or does the patient have a contraindication that would prohibit an 8-week trial of any of the following: A) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), B) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), C) Antidepressants (e.g., amitriptyline, venlafaxine)? ❑ Yes ❑ No

9. Does the patient require more than the plan allowance of any of the following: A) 1 injection of 140mg or 2 injections of 70mg per month of Aimovig, B) 3 injections (225mg each) per 3 months of Ajovy, C) 3 single dose vials (100mg each) for intravenous infusion per 3 months of Vyepti? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756