Kansas Medical Assistance Program	Amerigroup	Sunflower	UnitedHealthcare
PA Phone 800-933-6593	PA Pharmacy Phone 800-454-3730	PA Pharmacy Phone 877-397-9526	PA Pharmacy Phone 800-310-6826
PA Fax 800-913-2229	PA Pharmacy Fax 844-512-8999	PA Pharmacy Fax 866-399-0929	PA Pharmacy Fax 866-940-7328

Prior Authorization Form for CGRP Antagonists

Erenumab-aooe (Aimovig™)
Fremanezumab-vfrm (Ajovy™)

Beneficiary Information

Name: _____ Medicaid ID: _____

Date of Birth: _____ Gender: _____

Prescriber Information

Name: _____ Medicaid ID: _____

NPI: _____ Phone: _____ Fax: _____

Clinical Prior Authorization for INITIAL Approval of CGRP Antagonists

Medication Requested: _____ NDC: _____

What is the patient's diagnosis related to this request?

- ☐ **Chronic migraine** – Defined as 15 or more headache days per month, for more than 3 months, which, on at least 8 days/month, has the features of migraine headache.
- ☐ **Episodic migraine** – Defined as less than 15 headache days per month
- ☐ **Other** – Specify diagnosis: _____

Document the number of headache days per month the patient is experiencing (baseline, prior to treatment with requested agent):

- Baseline: _____

Has the patient experienced an inadequate response after a trial of two or more preventive therapies after titration to maximum tolerated doses (trial of at least 60 days), OR does the patient have a documented intolerance or contraindication to two or more preventive therapies (preventive therapies included, but are not limited to beta-blockers, calcium channel blockers, anticonvulsants and antidepressants)? ☐ **Yes** ☐ **No**

- If **yes**, provide documentation of previous medication trials (i.e. medication name, trial date, outcome of trial).
  - Medication Name: _____ Date of trial: _____ Outcome: _____
  - Medication Name: _____ Date of trial: _____ Outcome: _____

Does the prescriber attest that all medication-specific safety criteria for the medication requested is met? ☐ **Yes** ☐ **No**

- ☐ Ajovy™ (fremanezumab-vfrm) –
  - Patient is ≥ 18 years of age
  - Dose does not exceed either 225 mg (1.5 mL/1 syringe) per month OR 675 mg (4.5 mL/3 syringes) every 3 months
- ☐ Aimovig™ (erenumab-aooe) –
  - Patient is ≥ 18 years of age
  - Dose must not exceed 140 mg (2 mL/2 syringes) per month

PATIENT NAME:		MEDICAID ID:	

Clinical Prior Authorization for RENEWAL of All Agents

Document the number of headache days per month the patient is currently experiencing (while on treatment, compared to baseline):

- Baseline: _____ Date of result: _____
- Current: _____ Date of result: _____

Does the patient meet one of the following? ☐ **Yes** – please specify ☐ **No**

☐ Patient has experienced a reduction in the number of monthly headache days compared to baseline (prior to starting treatment with the requested agent).

☐ Patient has experienced a reduction in the number of monthly headache days of at least moderate severity compared to baseline (prior to starting treatment with the requested agent).

Does the prescriber attest that all medication-specific safety criteria, specified below, continues to be met? ☐ **Yes** ☐ **No**

☐ Ajovy™ (fremanezumab-vfrm) –
- Patient is ≥ 18 years of age
- Dose does not exceed either 225 mg (1.5 mL/1 syringe) per month OR 675 mg (4.5 mL/3 syringes) every 3 months

☐ Aimovig™ (erenumab-aooe) –
- Patient is ≥ 18 years of age
- Dose must not exceed 140 mg (2 mL/2 syringes) per month

Prescriber's Signature: _____ Date: _____

This form will be returned unprocessed if it is not completed in its entirety.