Migraine Agents: CGRP Receptor Antagonists (Acute)

Please fax this completed form to (866) 399-0929 OR mail to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID of Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation of one of the following after CGRP antagonist administration?
   - ☐ Reduction in pain, or pain freedom
   - ☐ Reduction in migraine-associated symptoms (i.e. photophobia, phonophobia, and nausea)

2. Indicate the patient's diagnosis:
   - ☐ Migraine headache
   - ☐ Other. Specify: _____

3. Has prescriber ruled out medication overuse headache? ☐ Yes ☐ No

4. Is patient experiencing at least two migraine episodes with moderate to severe pain per month during the last 3 months? ☐ Yes ☐ No

5. Indicate if patient has had an inadequate treatment response to the following (check all that apply):
   - ☐ At least 2 different 5-hydroxytryptamine (5HT) receptor agonists (triptans)
   - ☐ At least one triptan used in combination with a non-steroidal anti-inflammatory drug (NSAID)
   - ☐ NSAIDs are contraindicated
   - ☐ Triptans are contraindicated

6. Wil this be prescribed in combination with any other CGRP antagonist (i.e. Emgality, Aimovig, Ajovy)?
   ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)