Migraine Agents: Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist (Prophylaxis)

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 or 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, have there been a reduction in headache days from baseline? ☐ Yes ☐ No

2. Indicate the patient's diagnosis:
   ☐ Migraine headaches* ☐ Episodic cluster headaches* ☐ Other. Specify: _____
   *As defined by the International Classification of Headache Disorders 3rd edition (ICHD-3)

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

For the diagnosis of migraine headaches answer the following:

4. How many migraines per month does patient experience? _____

5. Indicate if patient has failed (defined as inability to reduce migraine headaches by two or more days per month) a 3-month trial from the following classes of preventative medications (check all that apply):
   ☐ Anticonvulsants: Topiramate or divalproex sodium
   ☐ Antidepressants. Venlafaxine, amitriptyline, or nortriptyline
   ☐ Beta-blockers. Propranolol, metoprolol, timolol or atenolol
   ☐ Contraindication/intolerance to treatments above. Explain: _____

6. Has patient received Botox (onabotulinum toxin) in the last 12 weeks? ☐ Yes ☐ No

For the diagnosis of cluster headaches answer the following:

7. Has patient tried and failed any of the following (check all that apply):
   ☐ Verapamil, taking a total daily dose of at least 360mg for at least 1 month
   ☐ Verapamil is contraindicated. Explain _____

Provide the following with request:
Chart notes, including documentation of MIDAS or HIT6 testing
For reauthorizations:
For migraines, documentation of reduction of migraine days and severity of migraines
For cluster headaches, documentation of continued need for therapy and reduction in attacks

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.)