CGRP Receptor Antagonists

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

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

2. Indicate patient's diagnosis:
   ☐ Cluster Headache* ☐ Migraine Prophylaxis *
   ☐ Migraine (Acute Treatment)* ☐ Other, specify: _____
   *As defined by the International Classification of Headache Disorders 3rd edition (ICHD-3)

3. Has the prescriber ruled out medication overuse headache (MOH)? ☐ Yes ☐ No

For the diagnosis of Migraines (prophylaxis):

4. If request is non-preferred, has patient had treatment with one or more preferred CGRP receptor antagonists indicated for migraine prophylaxis on the Apple Health Preferred Drug List (AHPDL) that was ineffective, contraindicated or not tolerated?
   ☐ Yes. List each medication and duration of trial:

   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____

   ☐ No. Explain why a preferred product(s) have not been tried: _____

For Reauthorization requests:

5. Is there documentation showing disease stability or improvement by as defined by one of the following?
   ☐ Migraine days reduced by at least 40% from baseline
   ☐ Significant improvement in Quality-of-Life measures (e.g. a 6-point reduction on the HIT-6 score)

For Initial request:

6. Will this be used in combination with other CGRP antagonists indicated for migraine prophylaxis [exception: rimegepant (Nurtec ODT) at a dose of less than or equal to 8 tablets per 30 days]? ☐ Yes ☐ No

7. How many migraines does the patient experience per month?
   Current _____ Date _____

8. 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):
   - ☐ Angiotensin receptor blockers: Candesartan
   - ☐ Anticonvulsants: Topiramate, divalproex sodium, or valproate
   - ☐ Antidepressants: Venlafaxine, amitriptyline, nortriptyline, or duloxetine
   - ☐ Beta-blockers: Propranolol, metoprolol, timolol or atenolol
   - ☐ Contraindication/intolerance to treatments above. Explain: _____

<u>For the diagnosis of Migraines (Acute Treatment):</u>

9. If request is non-preferred, has patient had treatment with one or more preferred CGRP receptor antagonists indicated for acute migraine treatment on the Apple Health Preferred Drug List (AHPDL) that was ineffective, contraindicated or not tolerated?
   - ☐ Yes. List each medication and duration of trial:

     Medication Name: _____ Duration: _____
     Medication Name: _____ Duration: _____
     Medication Name: _____ Duration: _____

   - ☐ No. Explain why a preferred product(s) have not been tried: _____

For Reauthorization requests:

10. Is there documentation showing disease stability or improvement by as defined by one of the following?
    - ☐ Clinically meaningful reduction in pain, or pain freedom, after CGRP antagonist administration
    - ☐ Clinically meaningful reduction in migraine-associated symptoms (i.e. photophobia, phonophobia, and nausea) after CGRP antagonist administration

For Initial request:

11. Will this be used in combination with other CGRP antagonists indicated for the acute treatment of migraines?
    ☐ Yes ☐ No

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

13. 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 (i.e., sumatriptan, naratriptan, rizatriptan)
    - ☐ At least one triptan (used in combination with a non-steroidal anti-inflammatory drug (NSAID)
    - ☐ NSAIDs are contraindicated
    - ☐ Triptans are contraindicated

<u>For the diagnosis of cluster headaches:</u>

For Reauthorization requests:

14. Has the patient experienced a reduction in total headache attacks per week compared to baseline?
    ☐ Yes ☐ No

15. Provider attests the patient continues to need therapy for cluster headache (i.e., the cluster period has not passed, or a trial of therapy taper has been attempted and was unsuccessful).
    ☐ Yes ☐ No

For Initial request:

16. 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: _____

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services 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.)