Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Prior Authorization (PA) Form for Antimigraine Drugs (Injectable CGRP Inhibitors)
Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Prior Authorization (PA) Form for Antimigraine Drugs (Injectable CGRP Inhibitors).** This PA form includes **Emgality (galcanezumab-gnlm) and Aimovig (erenumab-aooe).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a neurologist or pain management specialist with expertise in diagnosis/treating headache ? □ Yes □ No

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Diagnosis

□ Migraine
□ Cluster
□ Other: _____

6– Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

Clinical Criteria:

1. Member's age is ≥18 years or ≤ 75 years, **AND**
   □ No □ Yes

Migraine treatment:

2. Prescribed for treatment of chronic migraine (defined as ≥ 15 headache days [migraine-like or tension-like] per month for the past 3 months) or episodic migraine (≥ 8 days/month or ≥ 2 disabling migraines/month lasting at least 72 hours for the past 3 months),
   □ No □ Yes

3. **AND** member has a documented trial (≥2 months) with treatment failure, inadequate response, or contraindication to use to at least 3 preventative agents for migraine, 2 of which must include:
   - Tricyclic antidepressants (e.g., amitriptyline, nortriptyline)
   - Beta-blocker (e.g., metoprolol, propranolol)
   - SNRIs (e.g. venlafaxine, duloxetine)
   - Candesartan
   - Lisinopril
   - Topiramate
   - Valproate

   □ No □ Yes

4. **AND** member must have documented treatment failure or inadequate response to a ≥2-month trial of Ajovy before being approved for Emgality,
   □ No □ Yes

5. **AND** member must have documented treatment failure or inadequate response to a ≥2-month trial of Ajovy (preferred) and Emgality before being approved for Aimovig
   □ No □ Yes

Additional diagnoses covered for Emgality only:

1. Prescribed for the treatment of episodic cluster headache (≥ 2 cluster periods lasting from 7 days to 1 year, separated with pain-free remission periods between attacks ≥ 1 months), currently with frequency of attacks ≥1 attack every other day,
   □ No □ Yes

2. **AND** has a history of cluster headache period lasting ≥6 weeks?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member meets all the initial criteria for coverage,
   □ No □ Yes

2. **AND** after 3 months of treatment patient has positive clinical response
   □ No □ Yes

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**