Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Anti-migraine Preparations Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Anti-migraine Preparations.** 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. The 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

Provider Name: _____ Specialty:_____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Drug Name/Form: _____
Strength:_____
Dosing Frequency: _____
Length of Therapy: _____
Quantity per Day:_____
Sig: _____

Preventive treatment of migraine	
Preferred agents	**Non-preferred agents**
Aimovig®, Ajovy® and Ajovy® autoinjector	Emgality® syringe (100 mg)
Emgality® pen and syringe (120 mg), Nurtec® ODT	Qulipta™
Acute treatment of migraine	
Nurtec® ODT, Ubrelvy™	Reyvow®, Trudhesa® Zavzpret ®

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

If non-preferred agent is requested, please indicate why preferred agent cannot be used: _____
_____
_____

1. Is this request for initial or renewal of a prior therapy?
   ☐ Initial request ☐ Renewal request

For Initial request, complete the rest of the sections below. If therapy is approved, the length of approval is 6 months.

For renewal requests, complete the following question to receive a 12-month approval, and sign the form.

2. Did the patient demonstrate a significant decrease in the number, frequency, and/or intensity of headaches?

   ☐ YES ☐ NO

4 – Clinical Criteria

1. Is the member ≥ 18 years of age?

   ☐ Yes ☐ No

Preventive treatment of migraine, does the member meet the following criteria?

2. Does the member have a diagnosis of migraine with or without aura based on the International Classification of Headache Disorders (ICHD-III) diagnostic criteria? **AND**

   ☐ Yes ☐ No

3. Has the member had ≥ 4 migraine days per month for at least 3 months? **AND**

   ☐ Yes ☐ No

4. Has the member tried and failed a ≥ 1 month trial of any 2 of the following oral generic medications?

   - Antidepressants (e.g., amitriptyline, venlafaxine)
   - Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
   - Anti-epileptics (e.g., valproate, topiramate)
   - Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan)

   ☐ Yes ☐ No

Acute treatment of migraine, does the member meet the following criteria?

5. Does the member have a diagnosis of migraine with or without aura? **AND**

   ☐ Yes ☐ No

6. Has the member tried and failed (or has contraindications to) two preferred triptan medications?

   ☐ Yes ☐ No

7. Prior to initiation of Trudhesa™, a cardiovascular evaluation is recommended. Has this been completed?

   ☐ Yes ☐ No

Episodic Cluster Headache, does the member meet the following criteria?

8. Does the member have a diagnosis of episodic cluster headache? **AND**

   ☐ Yes ☐ No

9. Has the member experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months? **AND**

   ☐ Yes ☐ No

10. Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines? **AND**

    ☐ Yes ☐ No

11. Has the member tried and failed (or has contraindications to) at least one standard prophylactic (preventive) pharmacologic therapy for cluster headache?

    ☐ Yes ☐ No

5 – 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:**