AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-305-671-0200. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Migraine Treatment: Injectable Calcitonin Gene-Related Peptide (CGRP) **Antagonists**

Drug Requested: (Select one from below	· · · · · · · · · · · · · · · · · · ·
	PREFERRED
□ Aimovig® (erenumab)	□ Emgality® (galcanezumab)
N	NON-PREFERRED
□ Ajovy® (fremanezumab) *Member n PA criteria for approval of Ajovy*	nust have tried and failed <u>BOTH</u> preferred agents and meet all
MEMBER & PRESCRIBER INFO	DRMATION: Authorization may be delayed if incomplete.
Member Name:	
Member AvMed #: Date of Birth:	
Prescriber Name:	
Prescriber Signature:	Date:
Office Contact Name:	
Phone Number:	Fax Number:
NPI #:	
DRUG INFORMATION: Authoriza	tion may be delayed if incomplete.
Drug Name/Form/Strength:	
	Length of Therapy:
Diagnosis:	ICD Code, if applicable:
Weight (if applicable):	
 Will the member be discontinuing a prevantagonist medication if approved for red 	viously prescribed injectable calcitonin gene-related peptide (CGRP quested medication?
	□ Yes OR □ N

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	M. B. A. A. L. B.	
	approval along with the corresponding effective date.	
•	If yes, please list the medication that will be discontinued and the medication that will be initiated upo	n

Medication to be discontinued:	Effective date:	
Medication to be initiated:	Effective date:	

Recommended Dosing & Quantity Limits:

Drug	Dose	Quantity Limit
Aimovig® (erenumab)	Migraine Prophylaxis: Initial: 70 mg SC once a month; some members may benefit from 140 mg once a month (given as 2 consecutive 70 mg injections)	 70 mg/mL (1 mL/30 day) 140 mg dose (2 mL/30 days) If using the 140 mg dose, must use the package labeled specifically for 140 mg/mL
Ajovy® (fremanezumab)	 Migraine Prophylaxis for adults 18 years of age or older: 225 mg SC monthly or 675 mg every 3 months Migraine Prophylaxis for children ≥6 years and Adolescents ≤17 years, weighing ≥45 kg: 225 mg SC monthly 	 225 mg/1.5 mL; 1.5 mL (1 syringe) per 30 days or 4.5 mL (3 syringes) per 90 days
Emgality® (galcanezumab)	 Migraine Prophylaxis: Initial: 240 mg SC as a single loading dose, followed by 120 mg once monthly Episodic cluster headache prophylaxis: 300 mg SC at the onset of the cluster period and then once monthly until the end of the cluster period 	 120 mg/mL; 1 mL (1 auto-injector and prefilled syringe) per 30 days with one time loading dose of 2 mL (2 auto-injectors) For Episodic Cluster headache diagnosis only: 300 mg dose; 100 mg/mL prefilled syringe

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization Criteria

- \square Member must meet \underline{ONE} of the following age requirements:
 - □ For Aimovig & Emgality requests: Member must be 18 years of age or older
 - ☐ For Ajovy requests: Member must be 6 years of age or older and weigh 45 kg or more
- □ Provider has attested to all clinical criteria for <u>ONE</u> of the applicable diagnoses below

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DI	[A	GN	OSI	S:	Please check ONE of the applicable diagnoses below
		hro qua		&	Episodic Migraine Headache Prevention (All applicable boxes below must be met
		follo	owir Mer Mer prop treat evid	ng: nbe nbe bhy me enc An Bet An An	ticonvulsants (divalproex, valproate, topiramate) a blockers (atenolol, metoprolol, nadolol, propranolol, timolol) tidepressants (amitriptyline, venlafaxine) giotensin II receptor blocker (candesartan) *requires prior authorization* ectable CGRP inhibitors (Aimovig®, Emgality®, Ajovy®) or oral CGRP inhibitors indicated
		pref	·Ajo	vy	migraine prevention (Qulipta TM , Nurtec ODT [®]) *requires prior authorization* ® requests for members ≥ 18 years of age: Member must have tried and failed BOTH gents Aimovig® and Emgality® AND meet all prior authorization criteria for approval of
		Rec	ques abot	ulir	For concurrent use of Calcitonin Gene-Related Peptide (CGRP) inhibitors with Botox® numtoxinA) for migraine headache prevention (if applicable): Member must meet <u>ALL</u> the criteria (verified by chart notes and/or pharmacy paid claims):
			Mer	nbe	er must have a diagnosis of Chronic or Episodic Migraine Headache and is continuing to ence \geq 4 migraine headache days per month after receiving therapy with <u>ALL</u> the following
			1 • 1	mig of I nig	mber must have failed a 2-month trial of at least one medication from TWO different graine prophylactic classes supported by the American Headache Society/American Academy Neurology treatment guidelines 2012/2015/2021/2024, Level A and B evidence: ICSI 2013, h quality evidence: Anticonvulsants (divalproex, valproate, topiramate) Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
			[_	Antidepressants (amitriptyline, venlafaxine)
				_	Angiotensin II receptor blocker (candesartan) *requires prior authorization*
					mber must meet <u>ONE</u> of the following:
			[Member has had an inadequate response to a <u>2-month</u> trial with an injectable CGRP inhibitor (e.g., Aimovig [®] , Ajovy [®] , Emgality [®]) or an oral CGRP inhibitor indicated for migraine prevention (e.g., Nurtec [®] ODT, Qulipta [™]) *requires prior authorization*
			[Member has had an inadequate response to a <u>6-month</u> trial (2 injection cycles) of Botox [®] (onabotulinumtoxinA) *requires prior authorization*

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PA Migraine Treatment: Injectable CGRP Antagonists (AvMed) (Continued from previous page)

Episodic Cluster Headaches (Emgality® Only) (All applicable boxes below must be met to qualify)			
		Member has between one headache every other day and eight headaches per day	
	1 2 0 0	Member must have failed at least a 1-month trial of at least ONE generic standard prophylactic pharmacologic therapy, used to prevent cluster headache and supported by the American Headache Society/American Academy of Neurology treatment guidelines: Suboccipital steroid injection Calcium channel blockers (verapamil) Alkali metal/ Antimanic (lithium) Anticoagulant (warfarin) Anticonvulsants (topiramate)	

**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria. **

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.