MOLINA HEALTHCARE

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Service Authorization (SA) Form
ANTIMIGRAINE AGENTS, OTHERS

If the following information is not complete, correct, and legible, the SA process could be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: – –

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: – –

Fax Number: – –

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

Preventive treatment of migraine	
Preferred Agents *step edit required	**Non-Preferred Agents (SA required)**
Aimovig®, Ajovy® and Ajovy® autoinjector Emgality® pen and syringe (120 mg), Nurtec® ODT	Emgality® syringe (100 mg) Qulipta™
Acute treatment of migraine	
Preferred Agents (No SA with trial of 2 generic triptans)	**Non-Preferred Agents (SA required)**
Nurtec® ODT, Ubrelvy™	Reyvow®, Trudhesa™

Revised: 03232023 | Effective: 07/15/22

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

DRUG INFORMATION *(Continued)*

Please identify why the preferred agents cannot be used:

_____

DIAGNOSIS AND MEDICAL INFORMATION

All drugs in this class are eligible to receive a SIX (6)-month approval. Complete the following questions. For Preventive treatment of migraine, does the member meet the *step edit AND the following criteria?

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

   ☐ Yes ☐ No

2. Is the member ≥ 18 years of age? **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

For renewal, complete the following question to receive a TWELVE (12)-month approval.

1. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

   ☐ Yes ☐ No

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

For Acute treatment of migraine, does the member meet the *step edit AND the following criteria?

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

   ☐ Yes ☐ No

2. Is the member ≥ 18 years of age? **AND**

   ☐ Yes ☐ No

(Form continued on next page.)

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

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

For renewal, complete the following question to receive a TWELVE (12)-month approval.

2. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

   ☐ Yes ☐ No

Member's Last Name: **Member's First Name:**

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

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

   ☐ Yes ☐ No

2. Is the member ≥ 18 years of age**? AND**

   ☐ Yes ☐ No

3. 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

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

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

For renewal, complete the following question to receive a TWELVE (12)-month approval.

1. Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?

   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by Molina Complete Care.

The completed form may be faxed to (844) 278-5731, or you may call (800) 424-4518 (TTY/TDD:711)