

MOLINA HEALTHCARE 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:													
Filone Number.														
DRUG INFORMATION														
Drug Name/Form:														
Strength:														
Dosing Fraguency:														
	_													
Length of Therapy:														
Quantity per Day:														
Preventive t	reatment of migraine													
Preferred Agents *step edit required	Non-Preferred Agents (SA required)													
Aimovig®, Ajovy® and Ajovy® autoinjector	Emgality® syringe (100 mg) Qulipta™													
Emgality® pen and syringe (120 mg), Nurtec®														
ODT														
	Non Brotograd Agents (SA required)													
Preferred Agents (No SA with trial of 2 generic triptans)	Non-Preferred Agents (SA required)													
Nurtec® ODT, Ubrelvy™	Reyvow®, Trudhesa™													

MolinaHealthcare.com

MCC Virginia SA Form: Antimigraine Agents, Others

Member's Last Name:											Member's First Name:													
DR	DRUG INFORMATION (Continued)																							
Ple	Please identify why the preferred agents cannot be used:																							
DI	DIAGNOSIS AND MEDICAL INFORMATION																							
All	All drugs in this class are eligible to receive a SIX (6)-month approval. Complete the following																							
qu	questions. For Preventive treatment of migraine, does the member meet the *step edit AND the																							
fol	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 													n										
2		Yes] No > 10		of		. A.	ın															
۷. ۱	2. Is the member ≥ 18 years of age? AND																							
_		Yes	L	No													0.4							
3.		the Yes	mem 	ber f] No	nad ≥	≥ 4 m	iigrai	ne d	ays	per r	nont	h fo	or at	leas	t 3 m	onth	s? A	ND						
4.	*Ha	s the	men	nber	tried	and	faile	d a	≥ 1 r	nont	h tria	l of	f any	2 of	the	follov	ving	oral	gene	ric m	edic	ation	s?	
			lepre			-																		
			block epiler			-	-			-		mc	olol, a	atend	olol)									
			otens				-		-		•	iote	ensir	ı II re	ecept	or bl	ocke	rs (e	.g., li	sinor	oril, c	ande	sarta	an)
		Yes	\square N	lo																				
Fo	r ren	ewa	l, cor	nple	te th	e fo	llow	ing d	ques	stion	to r	ece	eive	a TV	VEL\	/E (1	2)- m	onth	n app	orova	al.			
1.	Did	the r	nemb	er d	emo	nstra	ıte si	gnifi	cant	deci	rease	e in	the	num	ber,	frequ	iency	, or	inten	sity (of he	adac	hes?	
		Yes		No												·				-				
				-																				
Me	mbe	r's L	ast N	lam	e:								Member's First Name:											
	r Ac teria		treat	mei	nt of	mig	grair	ne, c	does	s the	e me	ml	ber	mee	t the	*st	ер е	dit /	AND	the	follo	win	g	
1.	Doe	s the	e mer	nber	have	e a d	iagn	osis	of m	nigrai	ine w	/ith	or w	/itho	ut au	ra? /	AND							
	`	Yes] No																				
2.	Is th	e me	embe	r ≥ 1	8 ye	ars c	of ag	e? A	ND															
		Yes] No																				

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(Form continued on next page.)

MCC Virginia SA Form: Antimigraine Agents, Others

3.	*Has the member tried and failed (or has contraindications to) two preferred triptan medications?																							
	□Y	es		No																				
4.	Prior to initiation of Trudhesa™, a cardiovascular evaluation is recommended. Has this been completed?																							
	☐ Yes ☐ No																							
Fo	or renewal, complete the following question to receive a TWELVE (12)-month approval.																							
	Did th	-		-					-							•	•					adack	nes?	
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	ш.	00																						
Member's Last Name: Member's First Name:																								
Fo	r Epis	odic	Clu	ster	Hea	dacl	ne, c	loes	the	mer	nbe	r m	eet t	he fo	ollov	ving	crite	ria?						
1.																								
	Yes No																							
2.	Is the member ≥ 18 years of age ? AND																							
	Yes No																							
2																								
3.	pain-				•						•			asting	Tron	n / d	ays i	10 36	5 da	ys, s	epara	ated	by	
	Y	es		No																				
4.	Medi	catio	n wil	l not	he ii	hası	in co	nmhi	natio	א מר	ith a	noti	har (CRE	2 ant	ador	niet o	r inh	ihitor	LISA	d for	the		
т.	preve										itii a	100) (i (i	and	agoi	1131 0		ibitoi	usc	3 101	uic		
	Y	es		No																				
5.	Has to														at lea	ast o	ne st	anda	ard p	rophy	/lacti	С		
		es		No		J		, ,																
Fo	r rene	wal,	con	plet	e the	e fol	lowi	ng c	ques	tion	to r	ece	eive	a TW	/ELV	Έ (1	2)-m	onth	арр	rova	I.			
1.	Did th	ne m	emb	er de	emor	nstra	te si	gnifi	cant	decr	ease	e in	the	numl	ber, f	requ	ency	, or i	nten	sity c	f hea	adacl	nes?	
	ΩΥ	es		No																				
Dr.	ecrib	ner S	lians	iture	(Re	auir	eq)											Da	te					
Prescriber Signature (Required)																Da								

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 (800) 278-5731, or you may call (800) 424-4518 (TTY/TDD:711)