

Molina Complete Care

MOLINA COMPLETE CARE 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.

Last Name: Medicaid ID Number:	MEMBER INFORMATION														
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: Preferred agents require Clinical SA Non-Preferred agents (SA required) Emgality TM Syringe Emgality TM Pen Reyvow TM Reyvow TM Reyvow TM Reyvow TM Ubrelvy TM Please identify why the preferred agents cannot be used:	Last Name:	First Name:													
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: Preferred agents require Clinical SA Non-Preferred agents (SA required) Emgality TM Syringe Emgality TM Pen Reyvow TM Reyvow TM Reyvow TM Reyvow TM Ubrelvy TM Please identify why the preferred agents cannot be used:															
PRESCRIBER INFORMATION Last Name: Pirst Name:	Medicaid ID Number:	Date of Birth:													
PRESCRIBER INFORMATION Last Name: Pirst Name:															
PRESCRIBER INFORMATION Last Name: Pirst Name:															
Last Name: First Name:	Gender:	Weight in Kilograms:													
NPI Number: Phone Number: Fax Number: DRUG INFORMATION Drug Name/Form: Strength: Dosing Frequency: Length of Therapy: Quantity per Day: Preferred agents require Clinical SA Emgality™ Syringe Emgality™ Syringe Emgality™ Pen Ajovy™ Reyvow™ Ubrelvy™ Please identify why the preferred agents cannot be used:	PRESCRIBER INFORMATION														
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Ubrelvy™ Please identify why the preferred agents cannot be used:	Emgality™ Pen														
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	Please identify why the preferred agents cannot														
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MCC Virginia M4 SA Form: Antimigraine Agents, Other

/lemb	per's Last	Name	:			Me	Member's First Name:												
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oes t	the memb	er me	et the f	ollowin	g criter	ia?													
1.	Member Headach		-		•				a, ba	sed o	on th	e Inte	rnation	nal Cl	assifi	catio	n o		
	Yes		No																
2.	The men	nber is	18 yea	rs or old	ler; AN l	D													
	Yes		No																
3.	The mer	nber d	oes not	have m	edicati	on over	use he	eadacl	ne (N	10H)	; AN I	D							
	Yes		No																
4.	Women	of chil	dbearin	g age ha	ave had	l a preg	nancy t	est at	base	eline;	; ANI)							
	Yes		No																
5.	Member	· has ≥	4 migra	aine day	s per m	onth fo	r at lea	ıst 3 m	nonth	ns; A l	ND								
	Yes		No																
6.	Member life-style				tic inter	ventior	n moda	lities (e.g.,	beha	avior	al the	rapy, p	hysic	al th	erapy	, or		
	Yes		No																
7.	Member	has tr	ried and	l failed a	≥ 1-m	onth tri	al of ar	ıy 2 of	the	follo	wing	oral n	nedicat	ions	:				
	• B • A • A	Beta bl	ockers (ileptics ensin co	ts (e.g., a e.g., pro (e.g., va nverting	pranol Iproate	ol, meto e, topira	oprolol ımate)	, timo			-	or blo	ckers (e	e.g., l	isino	pril,			
	Yes		No																
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MCC Virginia M4 SA Form: Antimigraine Agents, Other

Иe	mber's Last Name:											Member's First Name:													
	 r renewal, complete the following questions to receive a TWELVE (12)-month approval. 8. Did the member demonstrate significant decrease in the number, frequency, and/or intensity of headaches? AND Yes No 																								
	 9. Does the member have an overall improvement in function with therapy? AND Yes No 10. Does the member continue to utilize prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, life-style modification)? AND Yes No 11. Will women of childbearing age continue to be monitored for pregnancy status? AND 																								
	 Yes													site											
Prescriber Signature (Required) 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 1-844-278-5731, or you may call the number below. CCC Plus: 1-800-424-4524 (TTY 711) Medallion 4.0: 1-800-424-4518 (TTY 711)																									

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