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: ______________________

Preferred agents require Clinical SA	Non-Preferred agents (SA required)
Emgality™ Syringe Emgality™ Pen	Aimovig™ Ajovy™ Reyvow™ Ubrelvy™

Please identify why the preferred agents cannot be used:

____

(Form continued on next page.)

© 2021 Molina Healthcare, Inc. All rights reserved.

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

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

DIAGNOSIS AND MEDICAL INFORMATION

Clinical edit all drugs in class to receive a THREE (3) month approval for these drugs. Complete the following section.

Does the member meet the following criteria?

1. Member has a diagnosis of migraine, with or without aura, based on the International Classification of Headache Disorders (ICHD-III) diagnostic criteria; **AND**

   ☐ Yes ☐ No

2. The member is 18 years or older; **AND**

   ☐ Yes ☐ No

3. The member does not have medication over-use headache (MOH); **AND**

   ☐ Yes ☐ No

4. Women of childbearing age have had a pregnancy test at baseline; **AND**

   ☐ Yes ☐ No

5. Member has ≥ 4 migraine days per month for at least 3 months; **AND**

   ☐ Yes ☐ No

6. Member is utilizing prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, or life-style modifications); **AND**

   ☐ Yes ☐ No

7. Member has tried and failed a ≥ 1-month trial of any 2 of the following oral 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

(Form continued on next page.)

© 2021 Molina Healthcare, Inc. All rights reserved.

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

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

For 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 ☐ No

12. Does the member continue to have an absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation)?

☐ 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 the Department of Medical Assistance Services.

The completed form may be faxed to **1-800-424-7581,** phoned to **1-800-424-4518 (TTY 711)** or mailed to:

Magellan Rx Management Prior Authorization Program
c/o Molina Complete Care
11013 West Broad Street
Glen Allen, VA 23060

© 2021 Molina Healthcare, Inc. All rights reserved.