Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

CGRP Antagonists, Chronic (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of CGRP Antagonists (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
AIMOVIG 140 MG DOSE-2 AUTOINJECTORS	AIMOVIG 70 MG/ML AUTOINJECTOR	AJOVY 225 MG/1.5 ML SYRINGE
EMGALITY 120 MG/ML PEN	EMGALITY 120 MG/ML SYRINGE	EMGALITY 300 MG (100 MG x 3 SYR)

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 90 days.
   If the answer to this question is no, go to question 2.

2. Is the medication being prescribed by or in consultation with a neurologist? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Is the patient greater than or equal to 18 years of age? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Does the patient have a history of chronic opioid therapy (greater than or equal to 60 day supply in the last 90 days)? Y N

If the answer to this question is yes, denied.
If the answer to this question is no, go to question 5.

5. Does the patient have a diagnosis of episodic migraines (defined as having between 4 and 14 migraine days per month and less than 15 headache days per month on average in the last 90 days)? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, go to question 6.

6. Does the patient have a diagnosis of chronic migraines (defined as having greater than or equal to 8 migraine days per month and greater than or equal to 15 headache days per month on average in the last 90 days)? Y N
   If the answer to this question is yes, go to question 9.
   If the answer to this question is no, go to question 7.

7. Is the request for Emgality? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, denied.

8. Does the patient have a diagnosis of episodic cluster headaches (defined as having two cluster periods lasting from 7 days to one year and separated by pain-free remission periods of greater than or equal to 3 months)? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

9. Does the patient have a history of a 60-day trial of 2 or more migraine prophylactic therapies in the last 365 days? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

10. Is the requested quantity less than or equal to the recommended dosing guidelines (see Table A below)? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, denied.

11. Is this request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 12.
    If the answer to this question is no, approved for 90 days.

12. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
    If the answer to this question is yes, approved for 90 days.
    If the answer to this question is no, go to question 13.

13. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    If the answer to this question is yes, approved 90 days.
    If the answer to this question is no, go to question 14.

14. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer to this question is yes, approved 90 days.
    If the answer to this question is no, denied.

Table A:

Dosing Guidelines		
Label Name	**Recommended Dose**	**Allowable Quantity**
Aimovig	70 mg monthly; some may benefit from 140 mg monthly	≤ 2 syringes/month
Ajovy	225 mg monthly; 675 mg every 3 months	≤ 1 syringe/month
Emgality	Migraine dosing: 240 mg loading dose followed by 120 mg monthly Episodic cluster headache dosing: 300 mg at the onset and then 300 mg monthly	Migraines: ≤ 1 syringe/month (starting with second dose) Episodic cluster headaches: ≤ 3 syringes/month

Comments:

I affirm that the information given on this form is true and accurate as of this date.

____ ____________________________

Prescriber (or Authorized) Signature Date