



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:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

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Date of Birth:

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Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

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Phone Number:

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Fax Number:

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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™, Vypti®
Acute treatment of migraine	
Preferred Agents (No SA with trial of 2 generic triptans)	Non-Preferred Agents (SA required)
Nurtec® ODT, Ubrelvy™	Reyvow®, Trudhesa™, Zavzpret™

Member's Last Name:

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Member's First Name:

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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:

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Member's First Name:

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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.)

