HIGHMARK | HIGHMARK

**Medication Prior Authorization Form**

**Fax to 1-866-240-8123**

# Aimovig

## Member Information:

| Subscriber's ID Number | | | Subscriber's Group Number |
|---|---|---|---|
| Member's Name | | Phone | Date of Birth |
| Address | City | State | Zip Code |

## Provider Information:

| Physician's Name | NPI | Phone | Fax |
|---|---|---|---|
| Address | City | State | Zip Code |
| Suite / Building | Physician's Signature | | Date |

## Medication Information:

| Drug Name | Drug Strength | Requested Quantity | Requested Day Supply |
|---|---|---|---|
| | | | ☐ 30 days<br>☐ 90 days<br>☐ Other: _____ |
| Directions | | | |

## Clinical Information:

1. Please select the member's diagnosis:
   - ☐ Episodic Migraine Prophylaxis (4-14 headache days per month)
   - ☐ Chronic Migraine Prophylaxis (15 or more headache days per month, of which 8 or more are migraine days)
   - ☐ Other (please list diagnosis and/or ICD -10 Code): _____

2. On average, how many days per month does the member experience a migraine (prior to starting Aimovig)?
   _____ days per month

3. Are the member's headaches caused by medication rebound or overutilization (taking narcotics or triptans exceeding more than 18 doses per month) or lifestyle factors (e.g., sleep patterns, caffeine use, etc.)?
   ☐ Yes ☐ No

4. Has the member experienced therapeutic failure or intolerance to any of the following?
   Please select **ALL** that apply:
   - ☐ Anti-epileptic drugs (e.g., topiramate, valproic acid, divalproex sodium, carbamazepine, etc.)
   - ☐ Beta-blockers (e.g., propranolol, timolol, metoprolol, etc.)
   - ☐ Calcium-channel blockers (e.g., verapamil, amlodipine, etc.)
   - ☐ Serotonin-norepinephrine reuptake inhibitors (e.g., venlafaxine, duloxetine, etc.)
   - ☐ Tricyclic antidepressants (e.g., amitriptyline, nortriptyline, etc.)
   - ☐ Botox
   - ☐ Alpha-agonists (e.g., clonidine, guanfacine, etc.)
   - ☐ ACE Inhibitors/Angiotensin II receptor blockers (e.g., lisinopril, candesartan, etc.)
   - ☐ Other: _____

5. Will the member use Aimovig for migraine prevention in combination with another CGRP inhibitor that will be used for acute use (e.g., Nurtec ODT, Ubrelvy, etc.)?
   ☐ Yes ☐ No

   If **YES**:
   a. Do the benefits of therapy outweigh the risks of concurrent use of both medications?
   ☐ Yes ☐ No

6. **For reauthorization requests:**

   Has the member experienced at least a 50% reduction in the number of migraine days per month compared to the start of therapy?
   ☐ Yes ☐ No

   If the member has a diagnosis of **episodic migraine**, has the member experienced a reduction of **at least 4** monthly migraine days since the start of therapy?
   ☐ Yes ☐ No

   If the member has a diagnosis of **chronic migraine**, has the member experienced a reduction of **at least 5** monthly migraine days since the start of therapy?
   ☐ Yes ☐ No

7. Please provide any additional information pertinent to this request:

   _____

   _____

   _____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the member. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

## INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   **NOTE:** *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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