HIGHMARK | HIGHMARK

Medication Prior Authorization Form

Fax to 1-866-240-8123

Ajovy

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 ☐ 90 days ☐ 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. Please provide the member's weight and include the unit of measure (for example, lb or kg): _____
3. On average, how many days per month does the member experience a migraine (prior to starting Ajovy)?

   _____ days per month
4. Are the member's headaches caused by medication rebound or overutilization or lifestyle factors?
   - ☐ Yes ☐ No

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

6. Will the member use Ajovy for migraine prevention in combination with another CGRP inhibitor that will be used for acute use (for example, 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

7. **If the member is currently on therapy with Ajovy:**

   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

8. 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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