HIGHMARK | HIGHMARK

Medication Prior Authorization Form

Fax to 1-866-240-8123

Emgality

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)
   - ☐ Episodic Cluster Headache (severe unilateral orbital, supraorbital, and/or temporal pain lasting 15 to 180 minutes when left untreated) → **For this diagnosis only, go to question 7**

   ☐ 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 Emgality? _____ 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 Emgality 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. Does the member need a loading dose of 240mg (i.e., 2 syringes or pens of Emgality 120mg)?
   ☐ Yes ☐ No

7. For **episodic cluster headache only**: is the member experiencing attack frequency of at least one attack every other day during a cluster period?
   ☐ Yes ☐ No

8. **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

   If the member has a diagnosis of **episodic cluster headache**, has the member experienced a reduction in the number of mean weekly cluster headaches from baseline?
   ☐ Yes ☐ No

9. 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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