

CGRP Antagonists - Colorado
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have one of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Chronic migraines <input type="checkbox"/> Episodic migraines <input type="checkbox"/> Episodic cluster headache
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure (after a trial of at least two months), contraindication, or intolerance to any of the following prophylactic therapies? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Amitriptyline (Elavil) <input type="checkbox"/> Atenolol <input type="checkbox"/> Metoprolol <input type="checkbox"/> Nadolol <input type="checkbox"/> Propranolol <input type="checkbox"/> Timolol <input type="checkbox"/> Divalproex sodium (Depakote/Depakote ER) <input type="checkbox"/> Topiramate (Topamax) <input type="checkbox"/> Venlafaxine (Effexor/Effexor XR) <input type="checkbox"/> Botox (OnabotulinumtoxinA)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Will the requested medication be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor?
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EPISODIC MIGRAINES

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have less than 15 headache days per month?
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have 4 to 14 migraine days per month?
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CHRONIC MIGRAINES

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have greater than or equal to 15 headache days per month?
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have greater than or equal to 8 migraine days per month?
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EPISODIC CLUSTER HEADACHE

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months?
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AJOVY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication, or intolerance to any of the following? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Aimovig <input type="checkbox"/> Emgality 120mg
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CONTINUATION OF THERAPY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity? <i>If yes, list positive response:</i>
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Provider Signature: _____ **Date:** _____

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