UnitedHealthcare
Community Plan

CGRP Inhibitors - Michigan
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: □ New or □ Continuation of Therapy? If continuation, list start date: ______________

Is this patient currently hospitalized? □ Yes □ 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? □ Yes □ 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

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
AIMOVIG & AJOVY	
□ Yes □ No	**Does the patient have a diagnosis of migraine with or without aura?**
□ Yes □ No	**Does the patient have ≥ 4 migraine days per month for at least 3 months?**
□ Yes □ No	**Has the patient tried and failed ≥ one-month trial of any of the following oral medications?** *(If yes, check which applies and complete Section D above)* □ Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan) □ Antidepressants (e.g., amitriptyline, venlafaxine) □ Anti-epileptics (e.g., topiramate, valproate) □ Beta blockers (e.g., atenolol, metoprolol, propranolol, timolol)
□ Yes □ No	**Has the patient had a therapeutic failure after a one-month trial of one preferred medication?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have an allergy to all preferred medications?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a contraindication or drug to drug interaction with all preferred medications?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a history of unacceptable side effects with all preferred medications?** *(If yes, complete Section D above)*
EMGALITY	
□ Yes □ No	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Cluster headaches □ Migraine with or without aura
□ Yes □ No	**Does the patient have ≥ 4 migraine days per month for at least 3 months?**
□ Yes □ No	**Has the patient tried and failed ≥ one-month trial of any of the following oral medications?** *(If yes, check which applies and complete Section D above)* □ Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan) □ Antidepressants (e.g., amitriptyline, venlafaxine) □ Anti-epileptics (e.g., topiramate, valproate) □ Beta blockers (e.g., atenolol, metoprolol, propranolol, timolol)
UBRELVY	
□ Yes □ No	**Does the patient have a diagnosis of migraine with or without aura?**
□ Yes □ No	**Has the patient tried and failed, or has a contraindication to one preferred triptan medication?** *(If yes, complete Section D above)*
CONTINUATION OF THERAPY – ALL REQUESTS	
□ Yes □ No	**Has the patient demonstrated a significant decrease in the number, frequency, and/or intensity of headaches?**

Provider Signature: ____ **Date:** ____________________

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