UnitedHealthcare Community Plan

Antimigraine Agents, Other - Pennsylvania
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	
ALL REQUESTS	
☐ Yes ☐ No	**Does the patient have a diagnosis of headache based on the current International Headache Society Classification of Headache Disorders?**
☐ Yes ☐ No	**Does the patient have a diagnosis of migraine with or without aura confirmed according to the current International Headache Society Classification of Headache Disorders?**
☐ Yes ☐ No	**Does the patient have a history of contraindication to the prescribed medication?**
HEADACHE	
☐ Yes ☐ No	**Does the patient have a history of trial and failure, contraindication, or intolerance to standard first-line abortive medications based on headache classification as recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, or American Academy of Family Physicians, American Headache Society)?** *(If yes, complete Section D above)*
MIGRAINE - AIMOVIG / AJOVY / EMGALITY	
☐ Yes ☐ No	**Is the requested medication prescribed by or in consultation with one of the following?** *(If yes, check which applies)* ☐ A neurologist ☐ A headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)
☐ Yes ☐ No	**Does the patient have documentation of baseline average number of migraine days and headache days per month?**
☐ Yes ☐ No	**Has the patient averaged four or more migraine days per month over the previous three months?**
☐ Yes ☐ No	**Does the patient have a history of therapeutic failure of preventive medication from any of the following three classes?** *(If yes, check which applies and complete Section D above)* ☐ Beta-blockers (e.g., metoprolol, propranolol, timolol) ☐ Antidepressants (e.g., amitriptyline, venlafaxine) ☐ Anticonvulsants (e.g., topiramate, valproic acid, divalproex)
☐ Yes ☐ No	**Will the patient be using the requested CGRP (calcitonin gene-related peptide) antagonist/inhibitor with botulinum toxin?**
☐ Yes ☐ No	**For Aimovig and Ajovy, does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred CGRP antagonists/inhibitors approved or medically accepted for the patient's diagnosis (see Preferred Drug List, "Antimigraine Agent, Other" section)?** *(If yes, complete Section D above)*
CONTINUATION OF THERAPY - HEADACHE	
☐ Yes ☐ No	**Has the patient experienced an improvement in headache pain control or duration?**
CONTINUATION OF THERAPY – MIGRAINE - AIMOVIG / AJOVY / EMGALITY	
☐ Yes ☐ No	**Does the patient have a reduction in the average number of migraine days or headache days per month from baseline?**
☐ Yes ☐ No	**Has the patient experienced a decrease in severity or duration of migraines from baseline?**

Provider Signature: ____ **Date:** ___________________

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