UnitedHealthcare Community Plan

CGRP (Calcitonin Gene-Related Peptide)
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 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 one of the following diagnoses?** *(If yes, check which applies)* □ Chronic Migraines □ Episodic Migraines □ Episodic Cluster Headache
□ **Yes** □ **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?** *(If yes, check which applies and complete Section D above)* □ Amitriptyline (Elavil) □ Atenolol □ Metoprolol □ Nadolol □ Propranolol □ Timolol □ Divalproex sodium (Depakote/Depakote ER) □ Topiramate (Topamax) □ Venlafaxine (Effexor/Effexor XR) □ Botox (OnabotulinumtoxinA)
□ **Yes** □ **No**	**Will the requested medication be used in combination with another CGRP (calcitonin gene-related peptide) antagonist or inhibitor?**
EPISODIC MIGRAINES	
□ **Yes** □ **No**	**Does the patient have less than 15 headache days per month?**
□ **Yes** □ **No**	**Does the patient have 4 to 14 migraine days per month?**
CHRONIC MIGRAINES	
□ **Yes** □ **No**	**Does the patient have greater than or equal to 15 headache days per month?**
□ **Yes** □ **No**	**Does the patient have greater than or equal to 8 migraine days per month?**
EPISODIC CLUSTER HEADACHE	
□ **Yes** □ **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?**
AJOVY	
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to any of the following?** *(If yes, check which applies and complete Section D above)* □ Aimovig □ Emgality 120mg
CONTINUATION OF THERAPY	
□ **Yes** □ **No**	**Has the patient experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity?** *If yes, list positive response:*

Provider Signature: _____ **Date:** _____