Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/illinois-medicaid/providers/pharmacy-guidelines.html

Antimigraine
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information						
Preferred Agent:	☐ **Aimovig**					
Non-Preferred Agents:	☐ Nurtec ODT	☐ Ubrelvy	☐ Ajovy	☐ Vyepti	☐ Emgality	☐ Reyvow
☐ Other, please specify:						

Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No	ICD-10 Code:	Diagnosis:
What medication(s) have been tried and failed for diagnosis? (please specify):		

Are there any contraindications to formulary medications? (if yes, please specify)	☐ Yes	☐ No

☐ **Renewal Request ONLY:**						
If PREVENTATIVE TREATMENT: Is there documentation of reduction in migraine headache days from baseline?		☐ Yes	☐ No	If ACUTE TREATMENT: Is there documentation of improvement shown through provider clinical assessment?	☐ Yes	☐ No
Will medication be used in COMBO with another CGRP antagonist OR with Botox?					☐ Yes	☐ No
Aimovig 140mg:	Was there T/F with Aimovig 70mg?	☐ Yes	☐ No	Vyepti 300mg: Was there T/F with Vyepti 100mg?	☐ Yes	☐ No
Reyvow:	Was there response to therapy (decrease in pain severity; decreased symptoms of photophobia, phonophobia, or nausea)?				☐ Yes	☐ No

Requested Medication Information			
Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: ______________________

Clinical Information

☐ Aimovig 140mg	Was there trial and failure with 70mg?	☐ Yes	☐ No	☐ Vyepti 300mg	Was there trial and failure with 100mg?	☐ Yes	☐ No
☐ Will medication requested be used with another CGRP antagonist OR Botox?					☐ Yes	☐ No	

Chronic Migraine

☐ **Aimovig**	☐ **Emgality**	☐ **Ajovy**	☐ **Vyepti**

Question		
Are headaches occurring on 15 or more days per month with at least 8 migraine days per month for more than 3 months?	☐ Yes	☐ No

There is inadequate response OR intolerable side effect to at least 2 medications for migraine prophylaxis from 2 different classes, for at least 2 months (check all that apply):	
	☐ Beta-Blockers: propranolol, metoprolol, atenolol, timolol, nadolol
	☐ Anticonvulsants: Valproic acid, or divalproex, topiramate
	☐ Antidepressants: Amitriptyline, nortriptyline, venlafaxine, duloxetine

Episodic Migraine

☐ **Aimovig**	☐ **Emgality**	☐ **Ajovy**	☐ **Vyepti**

Question		
☐ Are headaches occurring on < 15 days per month with 4 - 14 migraine days per month?	☐ Yes	☐ No

There is inadequate response OR intolerable side effect to at least 2 medications for migraine prophylaxis from 2 different classes, for at least 2 months (check all that apply):	
	☐ Beta-Blockers: propranolol, metoprolol, atenolol, timolol, nadolol
	☐ Anticonvulsants: Valproic acid, or divalproex, topiramate
	☐ Antidepressants: Amitriptyline, nortriptyline, venlafaxine, duloxetine

Episodic Cluster Headaches

☐ **Emgality**

Question			Question		
Are headaches occurring at maximum of 8 attacks per day OR minimum of 1 attack every other day?	☐ Yes	☐ No	Was there T/F with verapamil for PREVENTATIVE treatment OR sumatriptan (nasal or subcutaneous) for ACUTE treatment?	☐ Yes	☐ No

Acute Migraines

☐ **Ubrelvy**	☐ **Nurtec ODT**

Question			Question		
Will requested medication be used for moderate or severe pain intensity?	☐ Yes	☐ No	Is CrCl < 15mL/min?	☐ Yes	☐ No
Is there documented inadequate response OR intolerable side effects with 2 triptans?	☐ Yes	☐ No	is there a contraindication to triptan use?	☐ Yes	☐ No

☐ Ubrelvy ONLY

Question		
Does member experience > 8 migraine days per month?	☐ Yes	☐ No

☐ Nurtec ODT ONLY

Question			Question		
Does member experience > 15 migraine days per month?	☐ Yes	☐ No	Is there severe hepatic impairment (Child-Pugh class C)?	☐ Yes	☐ No

☐ Reyvow ONLY

Question			Question		
Is diagnosis for migraine with or without aura according to ICHD-III diagnostic criteria?	☐ Yes	☐ No	Is headache pain moderate to severe in intensity?	☐ Yes	☐ No
Was there a documented inadequate response OR intolerable side effects with at least 2 triptans for at least 1 month each?				☐ Yes	☐ No
Is there a contraindication to triptan use?	☐ Yes	☐ No	Will triptans be used concurrently?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.
Prescribing Provider's Signature: ________________________________ **Date:** ______________________

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.