



Fax completed prior authorization request form to 800-854-7614 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 www.mercycareaz.org/providers/complecare-forproviders/pharmacy

Calcitonin Gene-Related Peptide Receptor (CGRP) Antagonists 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:			Height:		
					<input type="checkbox"/> Male	<input type="checkbox"/> Female				
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 Agents:		<input type="checkbox"/> Ajovy			<input type="checkbox"/> Emgality 120mg/mL syringe and Pen ONLY					
Non-Preferred Agents:		<input type="checkbox"/> Aimovig	<input type="checkbox"/> Nurtec ODT	<input type="checkbox"/> Ubrelvy	<input type="checkbox"/> Vyepti	<input type="checkbox"/> 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)					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Initial Request		<input type="checkbox"/> Continuation of Therapy Request	
RENEWAL Requests ONLY:										
<input type="checkbox"/> PREVENTATIVE treatment										
Is there documentation of reduction in migraine headache days from baseline?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> ACUTE treatment										
Is there documentation of improvement shown through provider clinical assessment?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Will medication be used in COMBO with another CGRP antagonist OR with Botox?								<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Aimovig 140mg ONLY:					<input type="checkbox"/> Vyepti 300mg ONLY:					
Was there trial and failure with Aimovig 70mg?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there trial and failure with Vyepti 100mg?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Turn-Around Time for Review										
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> 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										
Directions for Use:				Strength:			Dosage Form:			
				Quantity:		Day Supply:		Duration of Therapy/Use:		
Was there documented trial and failure OR contraindication to Ajovy AND Emgality?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will medication requested be used in COMBO with another CGRP antagonist OR Botox?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Aimovig 140mg ONLY:				Did member have trial and failure with Aimovig 70mg?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<input type="checkbox"/> Vyepti 300mg ONLY:	Did member have trial and failure with Vyepti 300mg?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Migraine				
<input type="checkbox"/> Aimovig	<input type="checkbox"/> Emgality	<input type="checkbox"/> Ajovy	<input type="checkbox"/> Vyepti	
Are headaches occurring on 15 OR MORE days per month with at least 8 migraine days per month for > 3 months?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
There is documented inadequate response OR intolerable side effect to at least 2 medications for migraine prophylaxis from 2 different classes, for at least 2 months (check that apply):		<input type="checkbox"/> Beta Blockers: Propranolol, metoprolol, atenolol, timolol, nadolol		
		<input type="checkbox"/> Anticonvulsants: Valproic acid, divalproex, topiramate		
		<input type="checkbox"/> Antidepressants: Amitriptyline, nortriptyline, venlafaxine, duloxetine		
Episodic Migraine				
<input type="checkbox"/> Aimovig	<input type="checkbox"/> Emgality	<input type="checkbox"/> Ajovy	<input type="checkbox"/> Vyepti	
Does member have headaches occurring LESS THAN 15 days per month, with 4 to 14 migraine days per month?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
There is documented inadequate response OR intolerable side effect to at least 2 medications for migraine prophylaxis from 2 different classes, for at least 2 months (check that apply):		<input type="checkbox"/> Beta Blockers: Propranolol, metoprolol, atenolol, timolol, nadolol		
		<input type="checkbox"/> Anticonvulsants: Valproic acid, divalproex, topiramate		
		<input type="checkbox"/> Antidepressants: Amitriptyline, nortriptyline, venlafaxine, duloxetine		
Acute Migraines				
<input type="checkbox"/> Ubrelvy	<input type="checkbox"/> Nurtec ODT			
Will requested medication be used for moderate or severe pain intensity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is CrCl < 15mL/min?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there documented inadequate response OR intolerable side effects with at least 2 triptans?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there contraindication to triptan use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ubrelvy ONLY:				
Does member experience MORE THAN 8 migraine days per month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there End Stage Renal Disease (CrCl < 15 mL/min)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Nurtec ODT ONLY:				
Does member experience MORE THAN 15 migraine days per month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there severe hepatic impairment (Child-Pugh class C)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does member have End Stage Renal Disease (CrCl <15 mL/min OR is on hemodialysis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has there been trial and failure, intolerance, or contraindication to Ubrelvy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Episodic Cluster Headache				
<input type="checkbox"/> Emgality				
Are headaches occurring at MAX of 8 attacks per day OR MIN of 1 attack every other day?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> PREVENTATIVE TREATMENT				
Was there trial and failure with verapamil?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> ACUTE TREATMENT				
Was there trial and failure with sumatriptan (nasal or subcutaneous)?			<input type="checkbox"/> Yes	<input type="checkbox"/> 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 800-624-3879 to check the status of a request.