

Service Authorization (SA) Form
ANTIMIGRAINE AGENTS, OTHERS

If the following information is not complete, correct, and legible, the SA process could be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name:

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First Name:

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Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

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Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

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NPI Number:

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Phone Number:

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Fax Number:

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DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

Preferred agents require Clinical SA	Non-Preferred agents (SA required)
Emgality™ Syringe Emgality™ Pen	Aimovig™ Ajovy™ Reyvow™ Ubrelvy™

Please identify why the preferred agents can not be used:

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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DIAGNOSIS AND MEDICAL INFORMATION

Clinical edit all drugs in class to receive a **THREE (3) month approval for these drugs. Complete the following section.**

Does the member meet the following criteria?

1. Member has a diagnosis of migraine, with or without aura, based on the International Classification of Headache Disorders (ICHD-III) diagnostic criteria; **AND**

Yes No

2. The member is 18 years or older; **AND**

Yes No

3. The member does not have medication over-use headache (MOH); **AND**

Yes No

4. Women of childbearing age have had a pregnancy test at baseline; **AND**

Yes No

5. Member has ≥ 4 migraine days per month for at least 3 months; **AND**

Yes No

6. Member is utilizing prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, or life-style modifications); **AND**

Yes No

7. Member has tried and failed a ≥ 1 -month trial of any 2 of the following oral medications:

- Antidepressants (e.g., amitriptyline, venlafaxine)
- Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
- Anti-epileptics (e.g., valproate, topiramate)
- Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan)

Yes No

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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For renewal, complete the following questions to receive a TWELVE (12)-month approval.

- 8. Did the member demonstrate significant decrease in the number, frequency, and/or intensity of headaches? **AND**
 Yes No
- 9. Does the member have an overall improvement in function with therapy? **AND**
 Yes No
- 10. Does the member continue to utilize prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, life-style modification)? **AND**
 Yes No
- 11. Will women of childbearing age continue to be monitored for pregnancy status? **AND**
 Yes No
- 12. Does the member continue to have an absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation)?
 Yes No

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be faxed to **1-800-424-7581**, phoned to **1-800-424-4518 (TTY 711)** or mailed to:

Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
11013 West Broad Street
Glen Allen, VA 23060