SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

ANTIMIGRAINE DRUGS - OTHERS

Drug Requested: (Check below the drug that applies)

Preventive Treatment of Migraine	
Preferred Drugs Require step edit	**Non-Preferred Drugs** Require prior authorization and preferred drugs must be tried and failed first
❑ **Ajovy® and Ajovy® Auto-injector** (fremanezumab- vfrm) **Syringe** ❑ **Aimovig®** (erenumab-aooe) **Injection** ❑ **Emgality®** (galcanezumab-gnlm) **Pen and Syringe** (120 mg) ❑ **Nurtec® ODT** (rimegepant) ❑ **Qulipta™** (atogepant) **Tablets**	❑ **Emgality®** (galcanezumab-gnlm) **Syringe 100 mg** (cluster headaches 300 mg SQ) ❑ **Vyepti®** (eptinezumab-jjmr) **IV Injection** ****(Refer to Vyepti PA form)**
Acute Treatment of Migraine	
Preferred Drug No prior authorization required with a trial of two generic triptans	**Non-Preferred Drugs** Require prior authorization and preferred drugs must be tried and failed first
❑ **Nurtec® ODT** (rimegepant) ❑ **Ubrelvy™** (ubrogepant) Tablets	❑ **Reyvow®** (lasmiditan) **Tablets** ❑ **Zavzpret™** (zavegepant)

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MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Please identify why the preferred agents cannot be used:

_____

_____

_____

_____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval: 6 months

Does the member meet the following criteria?

1. Does the member meet the FDA indicated age for the requested product? ❑ Yes ❑ No
2. Which of the following is the member using for this medication? Check all that apply:
   - ❑ Preventive treatment of migraine (Aimovig®, Ajovy®, Emgality®, Nurtec™ ODT, Qulipta™)
   - ❑ Acute treatment of migraine (Nurtec™ ODT, Reyvow®, Ubrelvy™, Zavzpret™)
   - ❑ Treatment of episodic cluster headache (Emgality® 100mg syringe)
   - ❑ Other use (specify details): _____

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❑ For Acute Treatment of Migraine approval, the following *step edit AND criteria must be met:

1. Does the member have a diagnosis of migraine with or without aura? ❑ Yes ❑ No
2. Has the member tried and failed (or has contraindications to) **TWO** preferred triptans medications? ❑ Yes ❑ No
3. If requesting Reyvow® or Zavzpret™: member must have trial and failure of Nurtec™ ODT and Ubrelvy™ ❑ Yes ❑ No

❑ For Preventive Treatment of Migraine approval, the following *step edit AND criteria must be met:

1. Has the prescriber assessed baseline disease severity utilizing an objective measure/tool (e.g., International Classification of Headache Disorders (ICHD-III); Headache Impact Test [HIT-6]; monthly headache day [MHD]; Migraine Disability Assessment [MIDAS]; Migraine Physical Function Impact Diary [MPFID])? ❑ Yes ❑ No
2. Member has ≥ 4 migraine days per month for at least 3 months? ❑ Yes ❑ No
3. Has the member tried and failed a ≥ 1 month trial of any 2 of the following oral medications? ❑ Yes ❑ No
   - ❑ Antidepressants **(e.g., amitriptyline, venlafaxine)**
   - ❑ Beta blockers **(e.g., propranolol, metoprolol, timolol, atenolol)**
   - ❑ Anti-epileptics **(e.g., valproate, topiramate)**
   - ❑ Angiotensin converting inhibitors/angiotensin II receptor blockers **(e.g., lisinopril, candesartan)**
4. For Nurtec and Qulipta, has the member tried and failed one (1) of the preferred injectable agents? ❑ Yes ❑ No

❑ For Episodic Cluster Headache approval, the following criteria must be met:

1. Does the member have a diagnosis of episodic cluster headache? ❑ Yes ❑ No
2. Is the member ≥ 18 years of age? ❑ Yes ❑ No
3. Has the member experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain- free periods lasting at least three months? ❑ Yes ❑ No
4. Medication will not be used in combination with another CGRP antagonist or inhibitor used for the preventive treatment of migraines? ❑ Yes ❑ No
5. Has the member tried and failed (or has contraindications to) at least one standard prophylactic (preventive) pharmacologic therapy for cluster headache? ❑ Yes ❑ No

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Reauthorization Approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. Did the member demonstrate a significant decrease in the number, frequency, and/or intensity of headaches? ❑ Yes ❑ No

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/UPDATED/REFORMATTED: ~~9/30/2018; 11/3//2018; 2/17/2019; 4/11/2019; 6/19/2019; 9/7/2019; 6/18/2020; 12/29/2020; 6/29/2021; 11/12/2021; 1/6/2022; 2/11/2022;5/18/2022; 6/27/2022; 2/28/2023; 6/28/2023; 12/21/2023; 6/6/2024; 6/20/2025;~~ **10/20/2025**