SENTARA HEALTH PLANS

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.**

Migraine Treatment: Injectable Calcitonin Gene-Related Peptide (CGRP) Antagonists

Drug Requested: (Select one from below)

PREFERRED	
❑ **Aimovig®** (erenumab)	❑ **Emgality®** (galcanezumab)
NON-PREFERRED	
❑ **Ajovy®** (fremanezumab) ***Member must have tried and failed BOTH preferred agents and meet all PA criteria for approval of Ajovy***	

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:** _____

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- Will the member be discontinuing a previously prescribed injectable calcitonin gene-related peptide (CGRP) antagonist medication if approved for requested medication?

❑ Yes **OR** ❑ No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

Medication to be discontinued: _____ **Effective date:** _____

Medication to be initiated: _____ **Effective date:** _____

Recommended Dosing & Quantity Limits:

Drug	Dose	Quantity Limit
Aimovig® (erenumab)	• **Migraine Prophylaxis**: Initial: 70 mg SC once a month; some members may benefit from 140 mg once a month (given as 2 consecutive 70 mg injections)	• 70 mg/mL (1 mL/30 day) • 140 mg dose (2 mL/30 days) • If using the 140 mg dose, must use the package labeled specifically for 140 mg/mL
Ajovy® (fremanezumab)	• **Migraine Prophylaxis**: 225 mg SC monthly **or** 675 mg every 3 months	• 225 mg/1.5 mL; 1.5 mL (1 • syringe) per 30 days or 4.5 mL (3 syringes) per 90 days
Emgality® (galcanezumab)	• **Migraine Prophylaxis**: Initial: 240 mg SC as a single loading dose, followed by 120 mg once monthly • **Episodic cluster headache prophylaxis**: 300 mg SC at the onset of the cluster period and then once monthly until the end of the cluster period	• 120 mg/mL; 1 mL (1 auto-injector and prefilled syringe) per 30 days with one time loading dose of 2 mL (2 auto- injectors) • For Episodic Cluster headache diagnosis only: 300 mg dose; 100 mg/mL prefilled syringe

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.

Authorization Criteria

❑ Member must be 18 years of age or older

❑ Provider has attested to all clinical criteria for **ONE** of the applicable diagnoses below

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DIAGNOSIS: Please check **ONE** of the applicable diagnoses below

- ❑ **Chronic & Episodic Migraine Headache Prevention** (All applicable boxes below must be met to qualify)

- ❑ Member must have a diagnosis of Chronic or Episodic Migraine Headache defined by **BOTH** of the following:
  - ❑ Member has ≥ 4 migraine headache days per month
  - ❑ Member must have failed a **2-month** trial of at least one medication from **TWO** different migraine prophylactic classes supported by the American Headache Society/American Academy of Neurology treatment guidelines 2012/2015/2021/2024, Level A and B evidence: ICSI 2013, high quality evidence:
    - ❑ Anticonvulsants (divalproex, valproate, topiramate)
    - ❑ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
    - ❑ Antidepressants (amitriptyline, venlafaxine)
    - ❑ Angiotensin II receptor blocker (candesartan) ***requires prior authorization***
    - ❑ Injectable CGRP inhibitors (Aimovig®, Emgality®, Ajovy®) or oral CGRP inhibitors indicated for migraine prevention (Qulipta™, Nurtec ODT®) ***requires prior authorization***
- ❑ **For Ajovy® Requests:** Member must have tried and failed **BOTH** preferred agents Aimovig® and Emgality® **AND** meet all prior authorization criteria for approval of Ajovy®
- ❑ **Requests for concurrent use of Calcitonin Gene-Related Peptide (CGRP) inhibitors with Botox® (onabotulinumtoxinA) for migraine headache prevention (if applicable):** Member must meet **ALL** the following criteria **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ Member must have a diagnosis of Chronic or Episodic Migraine Headache and is continuing to experience ≥ 4 migraine headache days per month after receiving therapy with **ALL** the following criteria:
    - ❑ Member must have failed a **2-month** trial of at least one medication from **TWO** different migraine prophylactic classes supported by the American Headache Society/American Academy of Neurology treatment guidelines 2012/2015/2021/2024, Level A and B evidence: ICSI 2013, high quality evidence:
      - ❑ Anticonvulsants (divalproex, valproate, topiramate)
      - ❑ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
      - ❑ Antidepressants (amitriptyline, venlafaxine)
      - ❑ Angiotensin II receptor blocker (candesartan) ***requires prior authorization***
    - ❑ Member must meet **ONE** of the following:
      - ❑ Member has had an inadequate response to a **2-month** trial with an injectable CGRP inhibitor (e.g., Aimovig®, Ajovy®, Emgality®) or an oral CGRP inhibitor indicated for migraine prevention (e.g., Nurtec® ODT, Qulipta™) ***requires prior authorization***
      - ❑ Member has had an inadequate response to a **6-month** trial (2 injection cycles) of Botox® (onabotulinumtoxinA) ***requires prior authorization***

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❑ **Episodic Cluster Headaches (Emgality® Only)** (All applicable boxes below must be met to qualify)

- ❑ Member has between one headache every other day and eight headaches per day
- ❑ Member must have failed at least a **1-month** trial of at least **ONE** **generic** standard prophylactic pharmacologic therapy, used to prevent cluster headache and supported by the American Headache Society/American Academy of Neurology treatment guidelines:
  - ❑ Suboccipital steroid injection
  - ❑ Calcium channel blockers (verapamil)
  - ❑ Alkali metal/ Antimanic (lithium)
  - ❑ Anticoagulant (warfarin)
  - ❑ Anticonvulsants (topiramate)

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.*

***Approved by Pharmacy and Therapeutics Committee:** ~~7/19/2018; 1/10/2022; 8/17/2023; 5/23/2024;~~ **11/21/2024**
REVISED/UPDATED: ~~3/14/2019; 7/1/2019; 12/30/2019; 6/15/2020; 8/2/2021; 11/8/2021; 11/22/2021 1/10/2022; 2/24/2022; 6/15/2022; 8/26/2022; 3/2/2023; 9/18/2023; 5/22/2024; 7/01/2024~~ **12/11/2024**