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 information provided is not complete, correct, or legible, authorization may be delayed.**

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***	

Sentara Considers the use of concomitant therapy with Calcitonin Gene-Related Peptide Antagonists (CGRP) and Botox to be experimental and investigational, although safety and efficacy of these combinations has been established. In the event a member has an active Botox authorization on file and dual therapy is requested, all subsequent CGRP requests will be reviewed and assessed for medical necessity of combination therapy.

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

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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.

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

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, Level A and B evidence; ICSI 2013, high quality evidence:
    - ❑ Anticonvulsants (divalproex, valproate, topiramate)
    - ❑ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
    - ❑ Antidepressants (amitriptyline, venlafaxine)

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- ❑ Member will **NOT** be initiating botulinum toxin headache prophylaxis after starting the requested agent
- ❑ Requested medication will **NOT** be used in combination with Botox or another CGRP inhibitor indicated for migraine prevention
- ❑ **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

❑ **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.