Prior Authorization Criteria

Calcitonin Gene-Related Peptide Inhibitors

All requests for Calcitonin Gene-Related Peptide Inhibitors require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Calcitonin Gene-Related Peptide Inhibitors:

For all requests for calcitonin gene-related peptide inhibitors all of the following criteria must be met:

The member is 18 years of age and older

- Prescribed by or in consultation with a neurologist or a headache specialist
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.

Coverage may be provided with a diagnosis of episodic migraines prophylaxis and the following criteria is met:

- Documentation the member has 4 to 14 headache days per month
- Documentation that the member has tried and failed for at least 2 months (at optimal or maximum tolerated dose) or had an intolerance or contraindication to two different drug classes within the level A classification of prophylactic agents.
  - Level A prophylactic drugs include: Divalproex sodium, sodium valproate, topiramate, amitriptyline, metoprolol, timolol, and propranolol

Coverage may be provided with a diagnosis of chronic migraine prophylaxis and the following criteria is met:

- Documentation the member has at least 15 headache days per month for 3 or more months with at least 8 migraine days per month
- Documentation that the member has tried and failed for at least 2 months (at optimal or maximum tolerated dose) or had an intolerance or contraindication to two different drug classes within the level A classification of prophylactic agents.
  - Level A drugs include: Divalproex sodium, sodium valproate, topiramate, amitriptyline, metoprolol, timolol, and propranolol
- Documentation that the member has tried and failed for at least 6 months or had an intolerance or contraindication to Botox (onabotulinumtoxinA) (Botox requires a prior authorization)
- **Initial Duration of Approval**: 3 months
- **Reauthorization Criteria**
  - Documentation the member is having a reduced number of migraine days per month or a decrease in migraine severity
- **Reauthorization Duration of Approval**: 12 months

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

Updated: 09/2018
PARP Approved: 09/2018

CALCITONIN GENE RELATED PEPTIDE INHIBITORS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health[SM] Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: ____________pounds or ____________kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:______________________

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Member's Diagnosis: ☐ Episodic Migraine ☐ Chronic Migraine ☐ Other ______________________

For Episodic Migraine:

How many headache days per month does the member have? ____

For Chronic Migraine:

How many headache days per month does the member have? ____

How long has the member been experiencing migraines? ______________________

Does the member have at least 8 migraines per month? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Updated: 09/2018
PARP Approved: 09/2018

Member Name:			**DOB:**
Gateway ID:			
Medication Name	**Strength/ Frequency**	**Dates of Therapy**	**Status (Discontinued & Why/Current)**

REAUTHORIZATION

Has the member experienced a decrease in the severity or frequency of migraines? ☐ Yes ☐ No

Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date