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Ajovy® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	ZIP:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	ZIP:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)

Initial Authorization:	
1. Does the patient have a diagnosis of episodic migraines?	❑ Yes ❑ No
2. Does the patient have four to 14 migraine days per month, but no more than 14 headache days per month?	❑ Yes ❑ No
3. Does the patient have a diagnosis of chronic migraines?	❑ Yes ❑ No
4. Does the patient have greater than or equal to 15 headache days per month, of which at least eight must be migraine days for at least three months?	❑ Yes ❑ No
5. Has medication overuse headache been considered and have potentially offending medication(s) been discontinued?	❑ Yes ❑ No
6. Does the patient have a history of failure (after at least a two-month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine)?	❑ Yes ❑ No
7. Does the patient have a contraindication to BOTH Elavil (amitriptyline) and Effexor (venlafaxine)?	❑ Yes ❑ No
8. Does the patient have a history of failure (after at least a two-month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)?	❑ Yes ❑ No
9. Does the patient have a contraindication to BOTH Depakote/Depakote ER (divalproex sodium) and Topamax (topiramate)?	❑ Yes ❑ No
10. Does the patient have a history of failure (after at least a two-month trial) or intolerance to ONE of the following beta blockers: atenolol, propranolol, nadolol, timolol or metoprolol?	❑ Yes ❑ No
11. Does the patient have a contraindication to ALL of the following beta blockers: atenolol, propranolol, nadolol, timolol and metoprolol?	❑ Yes ❑ No
12. Has the patient had a trial and failure, contraindication, or intolerance to BOTH of the following: Aimovig and Emgality?	❑ Yes ❑ No

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Reauthorization:	
1. Has the patient experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity?	❑ Yes ❑ No
2. Has the use of acute migraine medications (e.g., NSAIDs, triptans) decreased since the start of CGRP therapy?	❑ Yes ❑ No
3. For chronic migraine, does the patient continue to be monitored for medication overuse headache (MOH)?	❑ Yes ❑ No

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern