Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Prior Authorization (PA) Form

ANTIMIGRAINE AGENTS, OTHERS

If the following information is not complete, correct, or legible, the PA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

Preferred Agents (PA required)	Non-Preferred Agents (PA required)
Emgality™ Syringe	Aimovig™
Emgality™ Pen	Ajovy™
	Reyvow™
	Ubrelvy™

Please identify why the preferred agents cannot be used:

_____

_____

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

Clinical edit: all drugs in class to receive a THREE (3)-month approval for these drugs. Complete the following questions.

Does the member meet the following criteria?

1. Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria? **AND**

   ☐ Yes ☐ No

2. Is the member 18 years or older? **AND**

   ☐ Yes ☐ No

3. The member does not have medication over-use headache (MOH). **AND**

   ☐ Yes ☐ No

4. Women of childbearing age have had a pregnancy test at baseline. **AND**

   ☐ Yes ☐ No

5. Member has ≥ 4 migraine days per month for at least 3 months? **AND**

   ☐ Yes ☐ No

6. Member is utilizing prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, or life-style modifications). **AND**

   ☐ Yes ☐ No

7. Member has tried and failed a ≥ 1 month trial of any 2 of the following oral medications:

   - Antidepressants (e.g., amitriptyline, venlafaxine)
   - Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
   - Anti-epileptics (e.g., valproate, topiramate)
   - Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan)

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

For renewal, complete the following questions to receive a TWELVE (12)-month approval.

8. Did the member demonstrate significant decrease in the number, frequency, and/or intensity of headaches? **AND**

   ☐ Yes ☐ No

9. Does the member have an overall improvement in function with therapy? **AND**

   ☐ Yes ☐ No

10. Does the member continue to utilize prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, life-style modification)? **AND**

    ☐ Yes ☐ No

11. Women of childbearing age continue to be monitored for pregnancy status. **AND**

    ☐ Yes ☐ No

12. Absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation).

    ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.

The completed form may be **FAXED TO 1-844-512-7020**.