Nevada Medicaid- Molina Healthcare

Calcitonin Gene-Related Peptide (CGRP) Receptor Inhibitor Medications Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Molina ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select all that apply:

Episodic Migraines:

- ❑ The recipient has a documented diagnosis of episodic migraines
- ❑ The recipient is 18 years of age or older
- ❑ The recipient has four to 14 migraine days per month, but no more than 14 headache days per month
- ❑ No other CGRP Inhibitor will be used in combination
- ❑ If the request is for continuation of therapy, the recipient has all of the following:
  - A documented positive response to the requested agent, demonstrated by a reduction in headache frequency and/or intensity
  - A decrease in the use of acute migraine medications (e.g., NSAIDs, triptans)

Indicate which of the following have been tried and failed after a two-month trial or the recipient has a contraindication:

❑ Amitriptyline	❑ Venlafaxine	❑ Divalproex
❑ Topiramate	❑ Atenolol	❑ Propranolol
❑ Nadolol	❑ Timolol	❑ Metoprolol

Chronic Migraines:

- ❑ The recipient has a documented diagnosis of chronic migraines
- ❑ The recipient is 18 years of age or older
- ❑ The recipient has been evaluated for medication overuse headache (MOH)
- ❑ If the recipient has a diagnosis of MOH, then there will be a treatment plan that will include a taper of the offending medication
- ❑ The recipient has ≥ 15 headache days per month, of which at least eight must be migraine days for at least three months
- ❑ No other CGRP Inhibitor will be used in combination
- ❑ The medication will not be used in combination with Botox (onabotulinumtoxinA)
- ❑ If the request is for continuation of therapy, the recipient has all of the following:
  - A documented positive response to the requested agent, demonstrated by a reduction in headache frequency and/or intensity
  - A decrease in the use of acute migraine medications (e.g., NSAIDs, triptans)
  - Continued monitoring for MOH

Indicate which of the following have been tried and failed after a two-month trial or the recipient has a contraindication:

❑ Amitriptyline	❑ Venlafaxine	❑ Divalproex
❑ Topiramate	❑ Atenolol	❑ Propranolol
❑ Nadolol	❑ Timolol	❑ Metoprolol

Clinical Information continued (required)

Select all that apply:

Acute Migraines:

- ❑ The recipient has a documented diagnosis of acute migraine with or without aura
- ❑ The recipient is 18 years of age or older
- ❑ The prescribed dose will not exceed two doses per migraine and treating no more than eight migraine episodes per 30 days
- ❑ The recipient has had at least one trial and failure of a triptan agent

  Document triptan agent: _____
- ❑ If the request is for continuation of therapy, the recipient had a documented positive response to therapy with the requested agent

Episodic Cluster Headaches:

- ❑ The recipient has a documented diagnosis of episodic cluster headache
- ❑ The recipient is 18 years of age or older
- ❑ The recipient has experienced at least two cluster periods lasting from seven days to 365 days, separated by pain-free periods lasting at least three months
- ❑ If the request is for continuation of therapy, the recipient had a documented positive response to therapy with the requested agent, demonstrated by a reduction in headache frequency and/or intensity

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

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.

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