

**State of Oklahoma
Oklahoma Health Care Authority
Aimovig™ (Erenumab-aooe) Prior Authorization Form**

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Pharmacy billing (NDC: _____ *NDC 55513-0841-02 is preferred for all regimens*) **Start Date:** _____
Dose: _____ **Regimen:** _____ **Fill Quantity:** _____ **Day Supply:** _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____
Provider Phone: _____ **Provider Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____
Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

***Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.*
For Initial Authorization (Initial approval will be for the duration of 3 months)**

1. What is the member's diagnosis?
 - Preventative treatment of migraines in adults
 - Other, please list: _____
2. Does the member have documented:
 - Chronic Migraine Headache
 - Episodic Migraine Headache
3. Date of member's migraine diagnosis? _____
4. Number of headache days per month? _____
5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)? _____
6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated?
 - a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes ___ No ___
 - b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes ___ No ___
7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated?
 - a. Hormone replacement therapy or hormone-based contraceptives? Yes ___ No ___
 - b. Chronic insomnia? Yes ___ No ___
 - c. Obstructive sleep apnea? Yes ___ No ___
8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes ___ No ___ If yes, please list:

Medication _____	Date Span _____	Dosing _____
Medication _____	Date Span _____	Dosing _____
Medication _____	Date Span _____	Dosing _____
9. Is the member taking any of the following medications **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain?
 - a. Decongestants (alone or in combination products)? Yes ___ No ___
 - b. Butalbital-containing medications? Yes ___ No ___
 - c. Opioid-containing medications? Yes ___ No ___
 - d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes ___ No ___
 - e. Ergotamine-containing medications? Yes ___ No ___
 - f. Triptans? Yes ___ No ___

If yes, to any of medications above, please list the medication(s) and the number of days per month taken: _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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State of Oklahoma
Oklahoma Health Care Authority
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Member Name: _____ Date of Birth: _____ Member ID#: _____

Criteria

Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

10. Is the member taking any medications that are **likely** to be the cause of the headaches? Yes ___ No ___
11. Has the member been evaluated within the last six months by a neurologist for migraine headaches and was Aimovig™ recommended as treatment? Yes ___ No ___
- a. If yes, please include name of neurologist recommending Aimovig™ treatment _____
12. Does the member currently use tobacco? Yes ___ No ___
13. Has the member been counseled on appropriate use, administration technique, and storage of Aimovig™? Yes ___ No ___

Additional Information: _____

For Continued Authorization (Compliance and information regarding efficacy will be required for continued approval):

1. Has the member been compliant with Aimovig™ (erenumab-aooe) treatment? Yes ___ No ___
2. Has the member responded well to treatment with Aimovig™ (erenumab-aooe)? Yes ___ No ___
3. Please provide the member's current number of migraine days per month: _____

Additional Information: _____

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Please complete and return all pages. Failure to complete all pages will result in processing delays.

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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