SoonerCare
Oklahoma Health Care Authority

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:_____**)**

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

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. Butalbital-containing medications? Yes ☐ No ☐
   b. Opioid-containing medications? Yes ☐ No ☐
   c. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes ☐ No ☐
   d. Ergotamine-containing medications? Yes ☐ No ☐
   e. 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:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Page 2 of 2—Please complete and return <u>all</u> 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:_____

_____

Please complete and return <u>all</u> 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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