REQUEST FOR PRIOR AUTHORIZATION

CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS

Aimovig (erenumab-aooe)

Prescribing Physician:	
Name (First, Last)	
Direct Phone #	
Fax #	
Physician specialty	

Patient:	
Name (First, Last)	
ID #	
Phone #	Client
Birth Date ___/___/_____	Sex M ☐ F ☐

Name and title of person completing form (please print)			
Drug name:	Strength:	Length of Therapy:	Quantity Requested:

Has patient been on this drug and, if yes, for how long at this dosage?

Patient's diagnosis requiring the use of this medication:

Has the patient tried or failed the following therapies?

- **Topiramate: Yes ❑ No ❑**
- **Divalproex sodium/Valproate sodium: Yes ❑ No ❑**
- **Beta-Blocker: metoprolol, propranolol, timolol, atenolol, nadolol: Yes ❑ No ❑**
- **Serotonin-norepinephrine Reuptake Inhibitor: venlafaxine, duloxetine: Yes ❑ No ❑**
- **OnabotulinumtoxinA: Yes ❑ No ❑**
- **Other: Yes ❑ No ❑ Please specify _____**

Please submit supporting documentation of use.

List the therapies tried and failed by the patient, include the duration of therapy:

Name of medication/therapy	Reason for failure	Duration of therapy

Is this a First-time request for a CGRP or a request for Continuation of Therapy? Initial ❑ Continuation ❑

Baseline Monthly Migraine Days (MMD): How many chronic migraines headaches (headache lasting ≥4 hours a day) is the patient experiencing per month (prior to CGRP therapy)?

Current Monthly Migraine Days (MMD): How many chronic migraines headaches (headache lasting ≥4 hours a day) is the patient experiencing per month with CGRP therapy?

Other Information. Submission of office visit progress notes are required for review:

Physician's Signature_____Date____/___/_____

Fax Request and Supporting Documentation to: SGRX @ 313-264-0985

For ScriptGuideRX use only)

Date faxed: ___/___/___

Date received: ___/___/___

Date completed: / /_____

Decision (all authorizations are pending valid eligibility)