PRIOR AUTHORIZATION REQUEST
AIMOVIG (ERENUMAB)

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

Patient:	
Name (First, Last)	
ID #	**Sex (at birth):** ❑ M ❑ F
Phone #	**Client**
Birth Date: ___/___/___	**Age**

Name and title of person completing form (please print):

Drug name: Aimovig	**Dose/Strength:** ❑70mg ❑140mg	**Frequency:** Monthly

Patient's diagnosis & ICD code requiring the use of this medication:

Has patient been on this drug? ❑Yes ❑No **If yes, for how long:** _____

Has the patient trialed Botox (botulinum toxin) for at least 2 cycles? ❑Yes ❑No
If yes, indicate dates: _____

Has the patient tried or failed at least TWO of the following therapies below for at least 8 weeks?

	Reason for failure	**Dates**
Antiepileptics ❑ Topiramate ❑ Divalproex/valproate sodium		**From** ___/___/___ **To** ___/___/___
Beta-blockers ❑ Atenolol ❑ Metoprolol ❑ Propranolol ❑ Nadolol ❑ Timolol		**From** ___/___/___ **To** ___/___/___
Antidepressants ❑ Amitriptyline ❑ Nortriptyline		**From** ___/___/___ **To** ___/___/___
❑ Candesartan		**From** ___/___/___ **To** ___/___/___
Other therapies		**From** ___/___/___ **To** ___/___/___

Indicate the number of headache days per month:

Of the headache days per month, how many are migraine days for the last 3 months:

indicate the disability assessment for migraines using MIDAS (Migraine Disability Assessment) or HIT-6 (Headache Impact test):

Physician's Name (print): _____ **Title:** _____

Physician's Signature: _____ **Date:** ___/___/___

Fax PA request form AND Supporting Documentation to: SGRX @ 313-264-0985