



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 <input type="checkbox"/> F <input type="checkbox"/>

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? <ul style="list-style-type: none"> • Topiramate: Yes <input type="checkbox"/> No <input type="checkbox"/> • Divalproex sodium/Valproate sodium: Yes <input type="checkbox"/> No <input type="checkbox"/> • Beta-Blocker: metoprolol, propranolol, timolol, atenolol, nadolol: Yes <input type="checkbox"/> No <input type="checkbox"/> • Serotonin-norepinephrine Reuptake Inhibitor: venlafaxine, duloxetine: Yes <input type="checkbox"/> No <input type="checkbox"/> • OnabotulinumtoxinA: Yes <input type="checkbox"/> No <input type="checkbox"/> • Other: Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Continuation <input type="checkbox"/>			
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 ____/____/____

Office Visit Chart Notes are required for the review

Fax Request to: SGRX @ 313-264-0985

For ScriptGuideRX use only)

Date faxed: ____/____/____
Date received: ____/____/____
Date completed: //____

Decision (all authorizations are pending valid eligibility)
