PRIOR AUTHORIZATION REQUEST

Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists

Prescribing Physician	
Name (First, Last)	
Physician Specialty	
Phone #	Fax #

Patient	
Name (First, Last)	
ID #	Sex (at birth) ☐ M ☐ F
Phone #	Client
Birth Date	Age

Name and title of person completing form (please print)

1. Please select ONE of the following:
- ☐ Aimovig (erenumab) 70mg SQ Monthly
- ☐ Aimovig (erenumab) 140mg SQ Monthly
- ☐ Nurtec (rimegepant) 75mg PO Every other day
- ☐ Nurtec (rimegepant) 75mg PO PRN
- ☐ Other: _____
  Drug name, dose, route, frequency

2. Patient's diagnosis use of this medication:
- ☐ Migraine Prevention
- ☐ Acute migraine treatment
- ☐ Other _____

3. Has patient been on this drug? ☐ Yes ☐ No

If yes, for how long: _____

4. Has the patient trialed Botox (botulinum toxin) for at least 2 cycles? ☐ Yes ☐ No

If yes, for how long: _____

5. Has the patient tried/failed at least TWO of the following therapies below for ≥ 8 weeks? ☐ Yes ☐ No

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

6. Indicate the number of headache days per month: _____

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

8. Indicated one of the following:
- ☐ HIT-6 (Headache Impact test): _____ ☐ MIDAS (Migraine Disability Assessment): _____

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

Physician's Signature _____ **Date** _____

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