TEXAS MEDICAID
Clinical Edit Prior Authorization
erenumab (AIMOVIG), fremanezumab (AJOVY), galcanezumab (EMGALITY)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the medication being prescribed by, or in consultation with, a Neurologist? [Manual Step]

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Does the client have a history of chronic opioid therapy? Chronic opioid therapy is defined as greater than or equal to (≥) 60 days supply of opioids in the last 90 days.

   ☐ Yes (Deny) ☐ No (Go to #4)

4. Does the client have a diagnosis of episodic migraines? Episodic migraines are defined as having between 4 and 14 migraine days per month and less than (<) 15 headache days per month on average in the last 90 days. [Manual Step]

   ☐ Yes (Go to #7) ☐ No (Go to #5)

5. Does the client have a diagnosis of chronic migraines? Chronic migraines are defined as having greater than or equal to (≥) 8 migraine days per month and greater than or equal to (≥) 15 headache days per month on average in the last 90 days. [Manual Step]

   ☐ Yes (Go to #7)

   ☐ No (And request is for EMGALITY, go to #6)

   ☐ No (And request is for AIMOVIG or AJOVY, Deny)

6. Does the client have a diagnosis of episodic cluster headaches? Episodic cluster headaches are defined as having 2 cluster periods lasting from 7 days to 1 year and separated by pain-free remission periods of greater than or equal to (≥) 3 months. [Manual Step]

   ☐ Yes (Go to #8) ☐ No (Deny)

7. Does the client have a history of a 60-day trial of two (2) or more migraine prophylactic therapies in the last 365 days?

   Examples include amitriptyline, atenolol (TENORMIN), divalproex (DEPAKOTE), metoprolol (TOPROL XL), nadolol, propranolol (INDERAL LA, INNOPRAN XL), timolol, topiramate (QUDEXY XR, TOPAMAX, TROKENDI XR), and venlafaxine (EFFEXOR XR). This is based on the American Academy of Neurology (AAN) and American Headache Society (AHS) 2012/2015 treatment guidelines. All drugs listed have a rating of "Strong Evidence (Level A and B)" for prevention of episodic migraine headaches.

   ☐ Yes (Go to #8) ☐ No (Deny)

8. Is the requested quantity less than or equal to (≤) the recommended dosing guidelines?

- AIMOVIG:
  - Recommended Dose: 70 mg monthly; some may benefit from 140 mg monthly
  - Allowable Quantity: ≤ 2 syringes/month
- AJOVY:
  - Recommended Dose: 225 mg monthly; 675 mg every 3 months
  - Allowable Quantity: ≤ 1 syringe/month
- EMGALITY: Migraine Dosing
  - Recommended Dose: 240 mg loading dose followed by 120 mg monthly
  - Allowable Quantity: ≤ 1 syringe/month (starting with second dose)
- EMGALITY: Episodic Cluster Headache Dosing
  - Recommended Dose: 300 mg at the onset and then 300 mg monthly
  - Allowable Quantity: ≤ 3 syringes/month

☐ Yes (Approve – 90 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.