Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Calcitonin Gene-Related Peptide (CGRP) Antagonists for Prophylaxis

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #10)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #10)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

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

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #9)

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

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Clinical Criteria (required)

10. Is this a renewal request?

- ◯ Yes (And the request is for an agent other than QULIPTA)
  (Go to #16)
- ◯ Yes (And the request is for QULIPTA)
  (Go to #17)
- ◯ No
  (Go to #11)

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

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

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

- ◯ Yes
  (Go to #15)
- ◯ No (And the request is for AIMOVIG, AJOVY, EMGALITY, or QULIPTA)
  (Go to #13)

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

- ◯ Yes
  (Go to #15)
- ◯ No (And request is for EMGALITY)
  (Go to #14)
- ◯ No (And request is for AIMOVIG, AJOVY, or QULIPTA) (Deny)
  (Go to #15)

14. Does the member have a diagnosis of episodic cluster headaches (defined as having two [2] cluster periods lasting from seven [7] days to one [1] year and separated by pain-free remission periods of greater than or equal to [≥] three [3] months)? [Manual]

- ◯ Yes
  (Go to #16)
- ◯ No (Deny)
  (Go to #16)

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

Examples of migraine prophylactic therapies 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). *Note: 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 migraine headaches.*

- ◯ Yes (And the request is for AIMOVIG, AJOVY, or EMGALITY)
  (Go to #16)
- ◯ Yes (And the request is for QULIPTA)
  (Go to #17)
- ◯ No (Deny)
  (Go to #16)

16. 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: less than or equal to (≤) two (2) syringes/month

AJOVY:
- Recommended Dose: 225 mg monthly; 675 mg every 3 months
- Allowable Quantity: less than or equal to (≤) one (1) syringe/month

EMGALITY: Migraine Dosing
- Recommended Dose: 240 mg loading dose followed by 120 mg monthly
- Allowable Quantity: less than or equal to (≤) one (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: less than or equal to (≤) three (3) syringes/month

◯ Yes (And the request is for AIMOVIG, AJOVY or EMGALITY)
(Go to #24)

◯ No (Deny)
(Go to #24)

◯ Not Applicable (n/a) (The request is for QULIPTA)
(Go to #17)

17. Does the member have a diagnosis of severe hepatic impairment in the last 365 days?

◯ Yes (Deny)
(Go to #18)

◯ No (And the request is for QULIPTA)
(Go to #18)

18. Does the member have a diagnosis of severe renal impairment or end-stage renal disease (ESRD) in the last 365 days?

◯ Yes
(Go to #20)

◯ No
(Go to #19)

19. Does the member have therapy with a strong CYP3A4 inhibitor in the last 90 days?

Examples of a CYP3A4 inhibitor include: atazanavir (REYATAZ), clarithromycin, CRIXIVAN, EVOTAZ, GENVOYA, INVIRASE, itraconazole (SPORANOX, TOLSURA), KALETRA, ketoconazole, KORLYM, lansoprazole-amoxicillin-clarithromycin (PREVPAC PAK), nefazodone, ritonavir (NORVIR), posaconazole (NOXAFIL), omeprazole-amoxicillin-clarithromycin (OMECLAMOX PAK), PREZCOBIX, PREZISTA, STRIBILD, SYMTUZA, TYBOST, voriconazole (VFEND), VIRACEPT, and ZYDELIG.

- ◯ Yes
  (Go to #20)
- ◯ No
  (Go to #21)

20. Is the requested dose greater than (>) 10 mg/day?

- ◯ Yes (Deny)
  (Go to #21)
- ◯ No
  (Go to #21)

21. Does the member have therapy with an organic anion transporting polypeptides (OATP) inhibitor in the last 90 days?

Examples of an OATP inhibitor include: atazanavir (REYATAZ), clarithromycin, cyclosporine (GENGRAF, NEORAL, SANDIMMUNE), erythromycin (E.E.S., ERYPED, ERY-TAB, ERYTHROCIN), gemfibrozil (LOPID), KALETRA, and rifampin (RIFADIN).

- ◯ Yes
  (Go to #22)
- ◯ No
  (Go to #23)

22. Is the requested dose greater than (>) 30 mg/day?

- ◯ Yes (Deny)
  (Go to #23)
- ◯ No
  (Go to #23)

23. Is the requested quantity less than or equal (≤) to one (1) tablet/day?

- ◯ Yes
  (Go to #24)
- ◯ No (Deny)
  (Go to #24)

24. Will the member have concurrent therapy with another calcitonin gene-related peptide (CGRP) antagonist for prophylaxis of migraines? Note: This plan will only cover one CGRP antagonist for prevention of migraine headaches at a time.

    Examples of CGRP antagonist include: erenumab (AIMOVIG), fremanezumab (AJOVY), galcanezumab (EMGALITY), rimegepant (NURTEC ODT), and atogepant (QULIPTA).

- ◯ Yes (Deny)
  (Go to #25)
- ◯ No (Approve - 365 days)
  (Go to #25)

Additional Information

25. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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