CGRP ANTAGONISTS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/star-kids-prior-auth

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis-ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For All Requests:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Please list all agents the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products. Please specify start and end dates of drugs tried).
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
3. Please list all other medications the patient will take **in combination** with the requested medication for the treatment of this diagnosis. _____
   _____
   _____
4. Please list all reasons for selecting the requested **agent, strength, dosing schedule, and quantity over alternatives** (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____
   _____
5. Does the patient have a diagnosis of severe hepatic impairment in the last 365 days? ☐ Yes ☐ No
6. Does the patient have a diagnosis of severe renal impairment in the last 365 days? ☐ Yes ☐ No
7. Does the patient have a diagnosis of end stage renal disease (ESRD) in the last 365 days? ☐ Yes ☐ No
8. Does the patient have a diagnosis of episodic migraines (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)? ☐ Yes ☐ No

For Aimovig/Ajovy/Emgality Requests:

9. Does the patient have a history of chronic opioid therapy (greater than or equal to 60-days supply in the last 90 days? ☐ Yes ☐ No
10. Does the patient have a diagnosis of chronic migraines (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)? ☐ Yes ☐ No
11. Does the patient have a diagnosis of episodic cluster headaches (defined as having two cluster periods lasting from 7 days to one year and separated by pain-free remission periods of greater than or equal to 3 months)? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For Nurtec/Ubrelvy Requests:

12. Does the patient have a diagnosis of migraine headache in the last 730 days? ☐ Yes ☐ No
13. Has the patient tried and failed therapy with at least 2 different triptans? ☐ Yes ☐ No
14. Does the patient have any FDA labeled contraindications to triptan therapy? ☐ Yes ☐ No

    If yes, please explain: _____

15. Has the patient been on a strong CYP3A4 inhibitor or inducer in the last 30 days? ☐ Yes ☐ No

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Please fax or mail this form to:
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Eagan, Minnesota 55121

TOLL FREE

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