

CAREFIRST ASO CGRP Receptor Antagonists Step Therapy

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of CGRP Receptor Antagonists Step Therapy.

Patient Information

[illegible]

Physician Information

[illegible]

Drug Name (specify drug)

Quantity: _____ Frequency: _____ Strength: _____

Route of Administration: _____ Expected Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please check the appropriate answer for each applicable question.

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|-----|---|---|--------------------------|---|--------------------------|
| 1. | Is the requested drug being prescribed for the preventive treatment of migraine in an adult patient? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. | Has the patient received at least 3 months of treatment with the requested drug? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. | Is this request for any of the following: A) Aimovig, B) Ajovy, C) Emgality 120 mg, D) Vyepti? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. | Has the patient had a reduction in migraine days per month from baseline? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. | Does the patient require MORE than the plan allowance of any of the following: A) 1 injection (70 mg or 140 mg) per month of Aimovig, B) 3 injections (225 mg each) per 3 months of Ajovy, C) 1 injection (120 mg) per month of Emgality, D) 3 single dose vials (100 mg each) for intravenous infusion per 3 months of Vyepti? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 6. | Is this request for any of the following: A) Aimovig, B) Ajovy, C) Vyepti? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 7. | Does the patient require MORE than the plan allowance of any of the following: A) 1 injection (70 mg or 140 mg) per month of Aimovig, B) 3 injections (225 mg each) per 3 months of Ajovy, C) 3 single dose vials (100 mg each) for intravenous infusion per 3 months of Vyepti? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 8. | Is this request for Emgality 120 mg? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 9. | Does the patient require MORE than the plan allowance of 4 injections (120 mg each) per first 3 months of Emgality (i.e., loading dose of 2 injections followed by 1 injection per month)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 10. | Is this request for Emgality 100 mg for the treatment of episodic cluster headache in an adult patient? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

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|-----|---|---|--------------------------|---|--------------------------|
| 11. | Has the patient received at least 3 weeks of treatment with the requested drug? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 12. | Has the patient had a reduction in weekly cluster headache attack frequency from baseline? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 13. | Does the patient require MORE than the plan allowance of 3 injections (100 mg each) per month of Emgality? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 14. | Has the patient experienced an inadequate treatment response to ANY of the following: A) sumatriptan (nasal or subcutaneous), B) zolmitriptan (nasal or oral)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 15. | Has the patient experienced an intolerance to or does the patient have a contraindication to ANY of the following: A) sumatriptan (nasal or subcutaneous), B) zolmitriptan (nasal or oral)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 16. | Does the patient require MORE than the plan allowance of 3 injections (100 mg each) per month of Emgality? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

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