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

Patient Name:
Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐
Patient ID:
Patient Group:
Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name
Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐
Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐
Physician Addr.:
City, St, Zip:

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.

1.	Is the requested drug being prescribed for the preventive treatment of migraine in an adult patient?	**Y** ☐	**N** ☐
2.	Has the patient received at least 3 months of treatment with the requested drug?	**Y** ☐	**N** ☐
3.	Is this request for any of the following: A) Aimovig, B) Ajovy, C) Emgality 120 mg, D) Vyepti?	**Y** ☐	**N** ☐
4.	Has the patient had a reduction in migraine days per month from baseline?	**Y** ☐	**N** ☐
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** ☐	**N** ☐
6.	Is this request for any of the following: A) Aimovig, B) Ajovy, C) Vyepti?	**Y** ☐	**N** ☐
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** ☐	**N** ☐
8.	Is this request for Emgality 120 mg?	**Y** ☐	**N** ☐
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** ☐	**N** ☐
10.	Is this request for Emgality 100 mg for the treatment of episodic cluster headache in an adult patient?	**Y** ☐	**N** ☐

11.	Has the patient received at least 3 weeks of treatment with the requested drug?	**Y** ☐	**N** ☐
12.	Has the patient had a reduction in weekly cluster headache attack frequency from baseline?	**Y** ☐	**N** ☐
13.	Does the patient require MORE than the plan allowance of 3 injections (100 mg each) per month of Emgality?	**Y** ☐	**N** ☐
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** ☐	**N** ☐
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** ☐	**N** ☐
16.	Does the patient require MORE than the plan allowance of 3 injections (100 mg each) per month of Emgality?	**Y** ☐	**N** ☐

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.

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Prescriber (Or Authorized) Signature and Date