Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
P.O. Box 5119, Helena, MT 59604
Phone 406.443.6002 . Toll-Free 1.800.395.7961
Fax 406.513.1928 . Toll-Free 1.800.294.1350

Montana Healthcare Programs Prior Authorization Request Form for Use of Injectable CGRP Inhibitors Aimovig™ (erunumab), Ajovy™ (fremanezumab) and Emgality™ (galcanezumab)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	Prescriber Fax:
Prescriber Name:	Prescriber Specialty (if applicable):	
Requested Drug: ☐ Emgality ☐ Aimovig ☐ Ajovy *(Approval subject to preferred drug list requirements)*	Dose:	

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

Please check appropriate diagnosis:

☐ **Episodic Migraine Prophylaxis or Chronic Migraine Prophylaxis**

☐ **Episodic Cluster Headaches** (Applies only to Emgality)

Episodic Migraine Prophylaxis or Chronic Migraine Prophylaxis

- ☐ Member is 18 years of age or older.
- ☐ Member has a history of inadequate response (trial of at least 2 months duration) to **TWO** prophylactic conventional therapies (**must include at least 2 separate therapeutic classes**) from the following:

Drug (please circle applicable drugs trialed)
amitriptyline or venlafaxine
atenolol, metoprolol, nadolol or propranolol
topiramate or divalproex

Episodic Cluster Headaches (applies only to Emgality)

- ☐ Member is 18 years of age or older.
- ☐ Member meets the International Classification of Headache Disorders diagnostic criteria for episodic cluster headaches: ☐ Yes ☐ No
- ☐ Member has experienced a minimum of one attack every other day and at least four attacks during the baseline period, not exceeding eight attacks per day: ☐ Yes ☐ No
- ☐ Member has a history of inadequate response (trial of at least 4 weeks duration), contraindication or intolerance to verapamil: ☐ Yes ☐ No Dates of use: _____

If NO, what other therapies have been trialed and when:

Drug name: _____ Date: _____

Quantity Limitations:
Aimovig: 2 x 70mg autoinjectors or pre-filled syringes per month

Ajovy: 1 X 225mg pre-filled syringe per month or 3 X 225mg pre-filled syringes every 3 months

Emgality:

- Migraine Prophylaxis: Loading dose of 2 X 120mg autoinjectors and then 1 X 120mg autoinjector per month
- Episodic Cluster Headache: 300mg per month, max of 600mg for 8 weeks

Initial authorization for treatment of Migraine Prophylaxis will be issued for 3 months.

Authorization for treatment of Episodic Cluster Headache (Emgality only) will be issued for 8 weeks.

☐ CONTINUATION OF THERAPY

Episodic Migraine Prophylaxis or Chronic Migraine Prophylaxis
Member has experienced a positive response to therapy, as demonstrated by a reduction in migraine frequency compared to number of migraine days at baseline has been chart documented: ☐ Yes ☐ No

Episodic Cluster Headache
Emgality will be approved for **NO MORE** than eight consecutive weeks of therapy, so no continuation of therapy approvals will be granted. For new attacks, member will have to meet the criteria above.

Reauthorization for treatment of Episodic Migraine Prophylaxis or Chronic Migraine Prophylaxis will be issued for 12 months.

Please complete form, including required attachments, and fax to:
1-800-294-1350

09/2022