OKLAHOMA Health Care Authority

SoonerSelect | aetna

State of Oklahoma SoonerCare

Ajovy® (Fremanezumab-vfrm) Prior Authorization Form

Member Name:_______________________ Date of Birth:_____________ Member ID#:_________________

Drug Information

Pharmacy billing (NDC:______________________) Start Date (or date of next dose):__________________
Dose:____________ Regimen:__________________________ Fill Quantity:________ Day Supply:_______

Billing Provider Information

Provider NPI:_____________________________ Provider Name:____________________________________

Provider Phone:___________________________ Provider Fax:_____________________________________

Prescriber Information

Prescriber NPI:________________________ Prescriber Name:_____________________________________

Prescriber Phone:________________ Prescriber Fax:________________ Specialty:__________________

Criteria

All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.
Page 1 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays*.

For Initial Authorization (Initial approval will be for the duration of 3 months):

1. What is the member's diagnosis?
   - ❑ Preventative treatment of migraines in adults
   - ❑ Other, please list:____
2. Does the member have documented:
   - ❑ Chronic Migraine Headache
   - ❑ Episodic Migraine Headache
3. Date of member's migraine diagnosis?_____________
4. Number of headache days per month?________
5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)?________
6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated?
   a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes____ No____
   b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes____ No____
7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated?
   a. Hormone replacement therapy or hormone-based contraceptives? Yes____ No____
   b. Chronic insomnia? Yes____ No____
   c. Obstructive sleep apnea? Yes____ No____
8. Has the member failed at least 2 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes____ No____ If yes, please list:
   Medication____________________________ Date Span________________ Dosing_______________________
   Medication____________________________ Date Span________________ Dosing_______________________
9. If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s):
   Medication(s)____
   Reason(s) for discontinuation prior to 8 weeks: ____
10. Is the member taking any of the following medications **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain?
    a. Decongestants (alone or in combination products)? Yes____ No____
    b. Combination analgesics containing caffeine and/or butalbital? Yes____ No____
    c. Opioid-containing medications? Yes____ No____
    d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes__ No__
    e. Ergotamine-containing medications? Yes____ No____
    f. Triptans? Yes____ No____

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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Ajovy® (Fremanezumab-vfrm) Prior Authorization Form

Member Name:___________________ Date of Birth:____________ Member ID#:____________________

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Page 2 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

For Initial Authorization (continued):

11. Is the member taking any of the medications, listed in Question 10., **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? Yes____ No____
    a. If yes, to any of the medication(s) listed in Question 10., please list the medication(s) and the number of days per month taken:
    ____
    ____
    b. If yes, to any of the medication(s) listed in Question 10., please provide additional information to support member's need for continued use of medication(s) known to cause overuse or rebound headaches:
    ____
    ____
12. Is the member taking any medications that are **likely** to be the cause of the headaches? Yes____ No____
13. Has the member been evaluated within the last six months by a neurologist for migraine headaches and was Ajovy® recommended as treatment? Yes____ No____
    a. If yes, please include name of neurologist recommending Ajovy® treatment______________________
14. Will member use Ajovy® concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor? Yes____ No____
15. If applicable, are other aggravating factors that contribute to the development of episodic/chronic migraine headaches being treated (e.g., smoking)? Yes____ No____ Not Applicable____
16. Has the member been counseled on appropriate use, administration technique, and storage of Ajovy®? Yes____ No____

Additional Information:____
____

For Continued Authorization (Compliance and information regarding efficacy will be required for continued approval):

1. Has the member been compliant with Ajovy® (fremanezumab-vfrm) treatment? Yes____ No____
2. Has the member responded well to treatment with Ajovy® (fremanezumab-vfrm)? Yes____ No____
3. Please provide the member's current number of migraine days per month:_________

Additional Information:____
____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

Prescriber Signature:___________________________________ Date:________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.
Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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