Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Emgality 120 mg/mL subcutaneous syringe [ ] Emgality 300 mg/3 mL (100 mg/mL x 3) subcutaneous syringe
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Episodic Migraines (EM)

[ ] Chronic Migraines (CM)

[ ] Episodic Cluster Headache(ECH)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q4: Does the member continues to be monitored for medication overuse headache? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinial rationale for the request) _____
(*Required)

Q5: Request is for Emgality 120 mg/mL strength only? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical strength) _____(*Required)

Q6: Has the member decreased use of acute migraine medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs] [e.g., ibuprofen, naproxen], triptans [e.g., eletriptan, rizatriptan, sumatriptan]) since the start of CGRP therapy? (Check only one that apply)

[ ] Yes

[ ] No (please specify the drug name, start and end date of therapy)
_____(*Required)

Q7: Will the medication be used in combination with another CGRP inhibitor for the preventive treatment of migraines? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____
(*Required)

[ ] No

Q8: Will the medication be used in combination with another injectable CGRP inhibitor? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____
(*Required)

[ ] No

Q9: Request is for Emgality 100 mg/mL strength only? (Check only one that apply)

[ ] Yes

[ ] No(please provide clinical strength) _____(*Required)

Q10: Does the member have experienced a positive clinical response to therapy demonstrated by a reduction in headache frequency and/or intensity? (Check only one that apply)

[ ] Yes (please provide document(s) supporting positive response to therapy)
_____(*Required)

[ ] No (please provide clinical rationale for the request for continuation of therapy)
_____(*Required)

Q11: Is the requested medication prescribed by or in consultation with an neurologist, headache specialist, or pain specialist? (Check only one that apply)

[ ] Yes (please provide prescriber's speciality) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q12: What is the member's diagnosis? (Check only one that apply)

[ ] Episodic Migraines (EM)

[ ] Chronic Migraines (CM)

[ ] Episodic Cluster Headache(ECH)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q13: Has the member have at least 4 but not more than 14 headache days per month? (Check only one that apply)

[ ] Yes (please specify number of headache days per month) _____ (*Required)

[ ] No (please specify number of headache days per month and please provide clinical rationale for the request) _____(*Required)

Q14: Has member's medication overuse headache been considered and potentially offending medication(s) have been discontinued? (Check only one that apply)

[ ] Yes (please specify name of drug(s) and date of discontinuation (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q15: Has the member had greater than or equal to 15 headache days per month, of which at least 8 must be migraine days for at least 3 months? (Check only one that apply)

[ ] Yes (please specify number of headache days per month) _____ (*Required)

[ ] No (please specify number of headache days per month and please provide clinical rationale for the request) _____(*Required)

Q16: Has the member had an inadequate response or intolerance to at least 2-month trial of Elavil (amitriptyline) or Effexor (venlafaxine)? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q17: Does the member have any contraindication(s) to both of the following: Elavil (amitriptyline), and Effexor (venlafaxine)? (Check only one that apply)

[ ] Yes (please specify drug name(s) , and corresponding contraindication(s)) _____(*Required)

[ ] No

Q18: Has the member had an inadequate response or intolerance to at least 2-month trial of Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q19: Does the member have any contraindication(s) to both of the following: Depakote/Depakote ER (divalproex sodium), and Topamax (topiramate)? (Check only one that apply)

[ ] Yes (please specify drug name(s) , and corresponding contraindication(s))
_____(*Required)

[ ] No

Q20: Has the member had an inadequate response or intolerance to at least 2-month trial of one of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q21: Does the member have contraindication(s) to all of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol? (Check only one that apply)

[ ] Yes (please specify drug name(s) , and corresponding contraindication(s))
_____(*Required)

[ ] No

Q22: Has the member had an inadequate response, intolerance or experienced contraindication(s) to Atacand (candesartan)? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q23: Has the member had an inadequate response or intolerance to at least 2-month trial of Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q24: Does the member have any contraindication(s) to both of the following: Depakote/Depakote ER (divalproex sodium), and Topamax (topiramate)? (Check only one that apply)

[ ] Yes (please specify drug name(s) , and corresponding contraindication(s))
_____(*Required)

[ ] No

Q25: Has the member had an inadequate response or intolerance to at least 2-month trial of one of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q26: Does the member have contraindication(s) to all of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol? (Check only one that apply)

[ ] Yes (please specify drug name(s) , and corresponding contraindication(s))
_____(*Required)

[ ] No

Q27: Has the member had an inadequate response, intolerance or experienced contraindication(s) to Atacand (candesartan)? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q28: Has the member had an inadequate response or intolerance to at least 2-month trial of one of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol? (Check only one that apply)

[ ] Yes (please specify drug name, corresponding intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q29: Does the member have contraindication(s) to all of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol? (Check only one that apply)

[ ] Yes (please specify drug name(s) , and corresponding contraindication(s))
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q30: Has the member had an inadequate response, intolerance or experienced contraindication(s) to Atacand (candesartan)? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q31: Will the medication be used in combination with another calcitonin gene-related peptide (CGRP) inhibitor for the preventive treatment of migraines? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____
(*Required)

[ ] No

Q32: Has the member experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q33: Will the medication used in combination with another injectable CGRP inhibitor? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____
(*Required)

[ ] No

Q34: Is the member at least 18 years old? (Check only one that apply)

[ ] Yes

[ ] No (please specify member's age and provide clinical rationale for the request)
_____(*Required)

Q35: Is the medication prescribed by or in consultation with a neurologist, headache specialist, or pain specialist? (Check only one that apply)

[ ] Yes (please specify prescriber specialty) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q36: Request is for one of the following Emgality strength? (Check only one that apply)

[ ] 120 mg/mL strength only (for Episodic Migraines and Chronic Migraines)

[ ] 100 mg/mL strength only (for Episodic Cluster Headache)

[ ] Other (please provide clinical rationale for the request) _____
(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	