Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: ______________________________ Strength: _______________ Directions: _______________________________________

Physician Name: ___________________________ Physician Phone #: __________________________ Specialty: _____________________

Physician Fax #: ______________________ Pharmacy Name: _____________________________Pharmacy Phone: ___________________

Horizon NJ Health

Calcitonin Gene-Related Peptide (CGRP) Inhibitors and Lasmiditan (Reyvow®)– Medical Necessity Request

****Complete pages 1 & 2 for Initial Requests Only****

General Questions

1. Does the member have medication overuse headache (aka drug-induced headache, medication-misuse headache, rebound headache)?
   - □ **Yes** - For members with medication overuse headaches: Does the member continue to have migraines despite discontinuing the overuse of drugs taken for acute and/or symptomatic treatment of headaches? □ **Yes** □ **No**
   - □ **No**
   - □ **Unknown** (has not been evaluated)
2. For Ubrelvy requests: Will the member be taking Ubrelvy with a strong CYP3A4 inhibitor (e.g., clarithromycin, ketoconazole)?
   □ **Yes** □ **No**

Please indicate the appropriate diagnosis and answer the associated questions below.

□ Acute Treatment (will take drug at migraine/aura onset)

1. For Nurtec requests only: Can the prescription be changed to Ubrelvy?
   - □ **Yes**: Please notify the pharmacy of the change and proceed to section to #2.
   - □ **No**: Please provide the clinical reason why and then proceed to section #2. ____

     ____
2. Please indicate member's pain intensity?
   - □ Mild
   - □ Moderate
   - □ Severe
3. How many migraine days does the member experience per month? ________ days
4. Can the member try a triptan (e.g. Sumatriptan, Rizatriptan (ODT), Naratriptan, etc) **instead** of the requested drug?
   - □ **Yes -** please provide a new script for triptan and cancel requested drug script
   - □ **No -** please provide reason why (if contraindicated, please provide specific contraindication): ______________________________

     ____
5. Will the member be receiving any other CGRP Inhibitor or Reyvow for acute migraine treatment together with the requested drug?
   - □ **Yes** – please provide the drug name(s) and reason for needing more than 1 drug:____

     ____
   - □ **No**

□ Treatment of Cluster Headaches

1. Please indicate if member has chronic or episodic cluster headaches:
   - □ **Chronic**
   - □ **Episodic**
   - □ **Unknown**
2. Does the member have at least one headache attack every other day? □ **Yes** □ **No**
3. Does the member have more than 8 headache attacks per day? □ **Yes** □ **No**
4. Can the member try Verapamil for prevention of cluster headaches instead of the requested drug?
   - □ **Yes** – please call in new script to pharmacy
   - □ **No** – please provide reason why (if contraindicated, please provide specific contraindication)

     ____

     ____
5. Can the member try Sumatriptan (nasal or subcutaneous) for acute treatment of cluster headaches instead of the requested drug?
   - □ **Yes** – please call in new script to pharmacy
   - □ **No** – please provide reason why (if contraindicated, please provide specific contraindication)

     ____

     ____

Physician office's signature*_________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: ______________________________ Strength: _______________ Directions: ___________________________________

Physician Name: ___________________________ Physician Phone #: __________________________ Specialty: ______________________

Physician Fax #: ______________________ Pharmacy Name: _____________________________Pharmacy Phone: ___________________

Horizon NJ Health
Calcitonin Gene-Related Peptide (CGRP) Inhibitors and Lasmiditan (Reyvow®)– Medical Necessity Request
** Initial Requests (continued)**

□ Migraine Prevention

1. For Ajovy, Nurtec, Qulipta, and Vyepti requests only: Can the prescription be changed to Aimovig or Emgality?
   □ **Yes**:
   - Which medication is it being switched to?____
   - Please notify the pharmacy of the change and proceed to section to #2.

   □ **No**: Please provide the clinical reason why and then proceed to section #2. ____
   ____

2. Please indicate if member has chronic or episodic migraines:
   □ **Chronic Migraine**
   □ **Episodic Migraine**
   □ **Unknown**

3. For Chronic Migraine prevention only: Does the member have ≥ 15 headache days/month with ≥ 8 migraine days/month for >3 months?
   □ **Yes** □ **No**

4. For Episodic Migraine prevention only: Does the member have <15 headache days per month with 4-14 migraine days per month?
   □ **Yes** □ **No**

5. Will the member be receiving another CGRP Inhibitor for migraine prevention together with the requested drug?
   □ **Yes** – Please provide the drug name(s) and reason for needing more than 1 drug: ____
   ____
   □ **No**

6. Please provide the names of the **drugs previously tried** for migraine prevention, length of trial, and reason(s) discontinued

Drug Name	**Trial Length** (e.g., # days, #months, etc.)	**Discontinuation Reason**

7. Please provide any specific contraindications the member has for any drugs used for migraine prevention:
   ____
   ____

□ Other: ____

Physician office's signature*__________________________________ Print Name________________________________
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: ______________________________ Strength: _______________ Directions: ____

Physician Name: ___________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: ______________________ Pharmacy Name: _____________________________Pharmacy Phone: ___________________

****Complete page 3 only for Subsequent/Renewal requests****

Please indicate the appropriate diagnosis and answer the associated questions below.

□ **Acute treatment of migraines** (will take drug at migraine/aura onset)

1. Has the member experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity?
   - □ **Yes**
   - □ **No**
2. Will the member be receiving any other CGRP Inhibitor or Reyvow for acute treatment of migraines together with the requested drug?
   - □ **Yes** – please provide the drug name(s): ____
   - □ **No**

□ **Migraine Prevention**

1. Has the member experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity?
   - □ **Yes**
   - □ **No**
2. Will the member be receiving any other CGRP Inhibitor for migraine prevention together with the requested drug?
   - □ **Yes** – please provide the drug name(s): ____
   - □ **No**

□ **Treatment of Episodic Cluster Headaches**

1. Has the member experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity?
   - □ **Yes**
   - □ **No**

□ **Other: ____**

Physician office's signature*________________________________ Print Name_______________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

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