TEL 215 494 9403
FAX 215 357 2129
Sam Maddula PharmD

Medication needs prior authorization

ATTN:

NAME:

DOB:

DRUG:

ID:

Fax the Completed Form to the Pharmacy

Please complete the form in its entirety and fax it back to us so that we can process this prescription once the prior authorization has been approved.

ANTIMIGRAINE AGENTS, OTHER – CGRP INHIBITORS PRIOR AUTHORIZATION FORM
(form effective 1/1/20)

BANK'S APOTHECARY
Specialty Pharmacy

FAX TO BANKS APOTHECARY FAX: 215 357 2129.

PRIOR AUTHORIZATION REQUEST INFORMATION		
□ New request □ Renewal request	# of pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION			
Patient name:		Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION			
Prescriber name:		Specialty:	
State license #:	NPI:		MA Provider ID#:
Street address:	Suite #:	City/state/zip:	
Phone:		Fax:	

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: □ Patient's Home □ Physician's Office □ Patient's Preferred Pharmacy Name:

Pharmacy Phone #:	Pharmacy Fax #:

□ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

CLINICAL INFORMATION

Product requested (clinical prior auth required):

□ Aimovig 70 mg/ml autoinjector (1 autoinjector/package)
□ Aimovig 140 mg/ml autoinjector (1autoinjector/package)
□ Aimovig 140 mg dose (2 x 70 mg autoinjectors/package)
□ _____

□ Ajovy 225 mg/1.5 ml syringe
□ Emgality 120 mg/ml pen
□ Emgality 120 mg/ml syringe
□ _____

Dose/directions	Quantity:	Refills:
Diagnosis (submit documentation):	DX code (required):	

Is the medication being prescribed by, or in consultation with, a neurologist or headache specialist? □ Yes, *Submit documentation of consultation, if applicable.* □ No

INITIAL REQUESTS

1. Has the patient averaged 4 or more migraine days per month over the past 3 months?
   □ Yes □ No
2. Does the patient have a confirmed diagnosis of migraine (with or without aura) according to the current International Headache Society Classification of Headache Disorders?
   □ Yes - *Submit documentation of diagnosis.* □ No
3. Does the patient have a history of trial and failure, contraindication, or intolerance of medications from the following 3 drug classes used for the prevention of migraine?
   □ anticonvulsants (e.g., divalproex, topiramate, valproic acid) □ antidepressants (e.g., amitriptyline, venlafaxine) □ beta blockers (e.g., metoprolol, propranolol, timolol)
   □ Yes - List medications tried:
   □ No
4. Will the patient be using botulinum toxin (e.g., Botox, Dysport, Myobloc, Xeomin) concomitantly with the requested medication?
   □ Yes - *Submit documentation of consultation, if applicable.* □ No
5. Request for a non-preferred agent: Has the patient tried and failed the preferred CGRP Inhibitor, Emgality? □ Yes □ No
6. Provide average number of migraine days and headache days per month:

RENEWAL REQUESTS

1. Since starting the requested medication, did the patient experience a reduction in the average number of headache or migraine days per month or decrease in severity and/or duration of headaches or migraines?
   □ Yes - S*ubmit documentation of clinical response.* □ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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