Wellpoint

Calcitonin Gene-Related Peptide Receptor (CGRP) Antagonists, Prophylaxis Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
			Specify:

7. Diagnosis:

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

☐ Yes ☐ No	Does the member have a diagnosis of episodic migraines (defined as having between 4 and 14 migraine days per month and less than 15 headache days per month on average in the last 90 days)?
☐ Yes ☐ No	Does the client have a diagnosis of chronic migraines (defined as having greater than or equal to (≥) 8 migraine days per month and greater than or equal to (≥) 15) headache days per month on average in the last 90 days)?
☐ Yes ☐ No	Does the client have a diagnosis of episodic cluster headaches (defined as having two cluster periods lasting from 7 days to one year and separated by pain-free remission periods of greater than or equal to (≥) 3 months)?
☐ Yes ☐ No	Does the client have a diagnosis of severe hepatic impairment in the last 365 days?
☐ Yes ☐ No	Does the client have a diagnosis of severe renal impairment or end-stage renal disease (ESRD) in the last 365 days?
☐ Yes ☐ No	Will the client have concurrent therapy with another CGRP Antagonist for prophylaxis of migraines?

For non-preferred agents:

☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.

☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class.

☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.