PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Self-administered CGRP Inhibitors - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Self-administered CGRP Inhibitors - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Aimovig (erenumab-aooe) Ajovy (fremanezumab-vfrm) Emgality (galcanezumab-gnlm)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 4.]

2. Has the patient's mean monthly headache days been reduced by 50 percent or greater relative to the patient's baseline prior to treatment? Y N _____

	[Note: Documentation must be submitted.]	
	[If yes, then no further questions.]	
3.	Has the patient had a reduction in any of the following validated migraine-specific patient-reported outcome measures: A) Migraine Disability Assessment (MIDAS): Reduction of 5 points or greater when baseline score is 11-20 OR reduction of 30 percent or greater when baseline score is greater than 20, B) Migraine Physical Function Impact Diary (MPFID): Reduction of 5 points or greater, C) Headache Impact Test (HIT-6): Reduction of 5 points or greater?	Y N
	[Note: Documentation must be submitted.]	
	[No further questions.]	
4.	Is this request for concurrent use with medical botulinum toxin injection OR concurrent use with another calcitonin gene-related peptide (CGRP) agent?	Y N
	[If yes, then no further questions.]	
5.	Is the patient 18 years of age or older?	Y N
	[If no, then no further questions.]	
6.	Is the requested drug being prescribed by or in consultation with a neurologist or pain specialist?	Y N
	[If no, then no further questions.]	
7.	Is this request for preventative chronic migraine management?	Y N
	[If no, then skip to question 10.]	
8.	Does the patient have a documented diagnosis of chronic migraine (greater than or equal to 15 headache days per month with 8 being migraine days with symptoms lasting 4 hours a day or longer)?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	
9.	Has the prescriber documented that the patient does not have medication-induced headaches from overuse of acute treatment agents (analgesics, triptans, ergots)?	Y N
	[Note: Documentation must be submitted.]	
	[If yes, then skip to question 12.]	
	[If no, then no further questions.]	
10.	Is this request for episodic migraine management?	Y N
	[If no, then skip to question 15.]	
11.	Does the patient have a documented diagnosis of episodic migraine (less than 15 days per month)?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	

12. Has the patient tried and failed medications from at least TWO of the following therapeutic classes used in standard therapy for migraine prophylaxis: A) Beta antagonists, B) Anticonvulsants, C) Antidepressants?	Y N	
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
13. Is this request for Ajovy?	Y N	
[If yes, then no further questions.]		
14. Has the patient had a documented trial and failure with Ajovy?	Y N	
[Note: Documentation must be submitted.]		
[No further questions.]		
15. Is this request for Emgality 100mg/ml?	Y N	
[If no, then no further questions.]		
16. Is this request for the treatment of episodic cluster headache?	Y N	
[If no, then no further questions.]		
17. Does the patient have a documented diagnosis of episodic cluster headache (cluster headache attacks in periods lasting from 7 days to one year, separated by pain-free periods lasting at least 3 months)?	Y N	
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
18. Has the prescriber documented that the patient has a maximum of 8 attacks per day, and a minimum of one attack every other day?	Y N	
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
19. Has the patient tried and failed verapamil and at least one of the following: A) Prednisone, B) Dexamethasone?	Y N	
[Note: Documentation must be submitted.]		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date