Prior Authorization Request Form for fremanezumab-vfrm (Ajovy)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. **Has the patient received this medication under the TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Ajovy*	☐ Yes (subject to verification) Proceed to question **14**	☐ No Proceed to question **2**
2. **Is this medication being prescribed by or in consultation with a neurologist**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **Is the patient 18 years of age or older?**	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. **Is the patient pregnant or actively trying to become pregnant?**	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **5**
5. **What is the indication or diagnosis?**	☐ Chronic migraines - Proceed to question **9** ☐ Episodic migraines - Proceed to question **6** ☐ All other diagnosis or indications – **STOP** **Coverage not approved**	
6. **Has the patient experienced three consecutive months of 8 migraine days per month?**	☐ Yes Proceed to question **9**	☐ No Proceed to question **7**
7. **Has the patient experienced three consecutive months of 4-7 migraine days per month?**	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. **Does the patient have at least moderate disability shown by Migraine Disability Assessment (MIDAS) Test score greater than 11 or Headache Impact Test-6 (HIT-6) score greater than 50?**	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**

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9. Will the patient use other calcitonin gene-related peptide (CGRP) inhibitors (such as Aimovig or Emgality) in combination with the requested medication?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Please note for the following questions, formulary migraine prophylactic drug classes include: • Prophylactic antiepileptic medications: valproate, divalproic acid, topiramate; • Prophylactic beta-blocker medications, examples include, metoprolol, propranolol, atenolol, nadolol, timolol; • Prophylactic antidepressants: amitriptyline, duloxetine, nortriptyline, venlafaxine.		Proceed to question **11**
11. Has the patient tried at least ONE drug from TWO of the above migraine prophylactic drug classes?	☐ Yes Proceed to question **12**	☐ No Proceed to question **13**
12. Has the patient experienced intolerance or failure after an adequate 2 month trial of at least ONE drug from TWO of the above migraine prophylactic drug classes? *(An adequate trial is generally considered to be 6 to 8 weeks in duration because of the amount of time required to achieve maximal benefit with therapy.)*	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Does the patient have a contraindication to at least ONE drug from TWO of the above migraine prophylactic drug classes?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
14. Has the patient had a reduction in mean monthly headache days of GREATER THAN OR EQUAL TO 50% relative to the pretreatment baseline (as shown by patient diary documentation or healthcare provider attestation)?	☐ Yes **Sign and date below**	☐ No Proceed to question **15**
15. Has the patient shown a clinically meaningful improvement in ANY of the following validated migraine-specific patient-reported outcome measures: **A) Migraine Disability Assessment (MIDAS):** • **a reduction of 5 points or more when baseline score is 11-20 or** • **a reduction of 30% or more when baseline score is greater than 20;** **B) Headache Impact Test (HIT-6): a reduction of 5 points or more;** **C) Migraine Physical Functional Impact Diary (MPFID): a reduction of 5 points or more**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[27 April 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: