

**NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Migraine Calcitonin Gene Related Therapy**



Beneficiary Information

1. Beneficiary Last Name: _____	2. First Name: _____	
3. Beneficiary ID #: _____	4. Beneficiary Date of Birth: _____	5. Beneficiary Gender: _____

Prescriber Information

7. Prescribing Provider NPI #: _____
8. Requester Contact Information Name: _____ Phone #: _____ Ext. _____

Drug Information

9. Drug Name: _____	10. Strength: _____	11. Quantity Per 30 Days: _____
12. Length of Therapy: <input type="checkbox"/> 3 Months <input type="checkbox"/> 6 Months <input type="checkbox"/> 12 Months	Other: _____	

Clinical Information

**MIGRAINE Treatment
Initial Request**

1. Does the beneficiary have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the beneficiary 18 years old or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the beneficiary have medication over-use headache (MOH)? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. If beneficiary is a woman of childbearing age, has she had negative pregnancy test at baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5. Has the beneficiary experienced 4 or more migraine days per month for at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is the beneficiary utilizing prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list: _____
7. Has the beneficiary tried and failed at least a month or greater trial of medications from at least 2 different classes from the following list of oral medications? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list medications tried _____ a. Antidepressants (e.g. amitriptyline, venlafaxine) b. Beta Blockers (e.g. propranolol, metoprolol, timolol, atenolol) c. Anti-epileptics (e.g. valproate, topiramate) d. Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g. lisinopril, candesartan) e. Calcium Channel Blockers (e.g. verapamil, nimodipine)

**EPISODIC CLUSTER HEADACHE Treatment
Initial Request**

1. Does the beneficiary have a diagnosis of Episodic Cluster Headache with at least two cluster periods lasting from 7 days to 1 year (when untreated) and separated by pain-free remission periods of at least 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the beneficiary 18 years old or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. If beneficiary is a woman of childbearing age, has she had negative pregnancy test at baseline? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. Is the beneficiary utilizing prophylactic intervention modalities (e.g. medication therapy)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list: _____
5. Is the beneficiary receiving no more than 300mg (administered as three consecutive injections of 100mg each) at the onset of the cluster headache period, and then monthly until the end of the cluster headache period? <input type="checkbox"/> Yes <input type="checkbox"/> No

Continuation Request for all diagnosis

1. Has the beneficiary demonstrated significant decrease in the number, frequency, and/or intensity of headaches and/or a decrease in the length of the cluster period? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the beneficiary experienced an overall improvement in function with therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the beneficiary continued to utilize prophylactic intervention modalities (e.g. behavioral therapy, physical therapy, life-style modifications, medications)? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. If beneficiary is a woman of childbearing age, is she continuing to be monitored for pregnancy status? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5. Is the beneficiary experiencing unacceptable toxicity (e.g. intolerable injection site pain, constipation)? <input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Prescriber: _____ Date: _____

**Prescriber Signature mandatory*

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.