Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

# Horizon NJ Health

## *Calcitonin Gene-Related Peptide (CGRP) Inhibitors and Lasmiditan (Reyvow®)– Medical Necessity Request*

***Complete pages 1&2 for Initial Requests Only****

1. Is the medication being used for migraines?
   - □ **No**
   - □ **Yes** - Is it being used for the prevention or acute treatment of migraines?
     - □ Acute Treatment (will take drug after the migraine starts)
     - □ Prevention (will take drug to keep the migraine from happening)
       - a. How many migraine days per month does the member have? _____
       - b. Do migraine attacks significantly interfere with the member's daily routines despite acute migraine treatment? **Yes or No**
       - c. Was the member overusing acute migraine treatment [defined as 10 or more days per month for ergot derivatives, triptans, opioids, combination analgesics, and a combination of drugs from different classes that are not individually overused OR 15 or more days per month for nonopioid analgesics, acetaminophen, and NSAIDs (including aspirin)]? **Yes or No**
       - d. Has the member tried and failed or had intolerances with acute migraine treatment? **Yes or No**
       - e. Does the member have hemiplegic migraine, migraine with brainstem aura, migraine with prolonged aura, and those who have previously experienced a migrainous infarction? **Yes or No**
       - f. Does the member have chronic migraines *(At least 15 headache days per month)*? **Yes or No**

2. Does the member have cluster headaches?
   - □ No – Proceed to Question #3
   - □ Yes
     - Does the member have a minimum of 1 attack every other day? **Yes or No**
     - Has the member had at least 5 cluster headache attacks? **Yes or No**
     - Have the attacks spanned a time period of at least 7 days to 1 year? **Yes or No**
     - Have the pain-free remission periods between the attacks lasted at least 3 months? **Yes or No**

3. Has the member been evaluated for medication-overuse headaches (aka drug-induced headache, medication-misuse headache, rebound headache)?
   - □ No – Proceed to Question #4
   - □ Yes
     - Does the member have medication overuse headaches? □ **Yes** – answer questions below □ **No** – Go to question #4
     - What medication(s) is causing the headache? _____
     - How many headache days per month does the member have? _____
     - How many days per month does the member take this medication? _____
     - How long has the member been taking this medication? _____
     - Does the member continue to have migraines despite discontinuing the overuse of drugs taken for acute and/or symptomatic treatment of headaches? **Yes or No**

4. Will the member be receiving any other CGRP Inhibitor or Reyvow with the requested drug? **Yes or No**. If Yes, please list the name of the drug(s):

_____

5. Does the member have any contraindications to any drugs that are typically used for migraine prevention or treatment (e.g, anticonvulsants, antidepressants, beta-blockers, triptans, acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs), generic Cafergot, generic Migranal)? **Yes or No**
   - If yes, please explain the contraindication and to what drug:

_____

**Physician office's signature*_____ Print Name_____**

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

_____

_____

6. **For Ubrelvy requests**, will the member be concurrently taking any strong CYP3A4 inhibitors (drugs such as nefazodone, saquinavir, Indinavir, nelfinavir, voriconazole, lopinavir, telithromycin, posaconazole, boceprevir, idelalisib)? **Yes or No**

*7.* Please document all medications the member has used for the given diagnosis, length of trial and discontinuation reasons.

| **Drug Name** | **Length of trial** (e.g., # days, #months, #years) | **Discontinuation Reason** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

****Complete page 3 only for Subsequent/Renewal requests****

**Please indicate the diagnosis and answer the associated questions below.**

□ **Preventative Treatment of Migraines**

1. Has the member had improvement in migraine prevention compared to baseline (reduction of migraine days/hours/frequency, reduction in acute abortive migraine medications/pain/level of disability, increase in functional capacity)? **Yes or No**

2. Will the member be receiving any other CGRP Inhibitor for migraine prevention with the requested drug? **Yes or No**. If Yes, please list the name of the drug(s):
_____

□ **Treatment of Episodic Cluster Headaches**

1. Has the member had a reduction in the frequency of cluster headache attacks compared to baseline?
**Yes or No**

□ **Acute treatment of migraines**

1. Has the member had a reduction in pain and/or symptoms compared to baseline? **Yes or No**

2. Will the member be receiving any other CGRP Inhibitor or Reyvow for acute treatment of migraines with the requested drug? **Yes or No**. If Yes, please list the name of the drug(s):
_____

**Physician office's signature*_____ Print Name_____**
***Form must be completed and signed by physician or licensed representative from the physician's office**