Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

Headache Therapy (Calcitonin Gene-Related Peptide [CGRP] Inhibitors)
Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ Aimovig (erenumab-aooe)
☐ Ajovy (fremanezumab-vfrm)
☐ Emgality (galcanezumab-gnlm)
☐ Nurtec (rimegepant)
☐ Qulipta (atogepant)
☐ Ubrelvy (ubrogepant)
☐ Vyepti (eptinezumab-jjmr)^

Dose, frequency, and duration of medication requested _____

^*This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.*

Indication (Check all that apply.)

☐ Cluster headache
☐ Migraine headache
  ☐ Prophylaxis. Frequency of migraine attacks (days/month) _____
  ☐ Acute treatment. Frequency of migraine attacks (number/month) _____
☐ Other _____

Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient
For hospital outpatient billing, provide department-specific facility NPI. _____
Drug NDC (if known) or service code _____

Section I. Please complete for Aimovig, Ajovy, Emgality, Nurtec, Qulipta, and Vyepti requests for migraine prophylaxis.

1. Has the member had a trial with a beta-blocker (atenolol, metoprolol, nadolol, propranolol, timolol)?
   ☐ Yes. Please list the drug name, dates/duration of use, and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain why not. _____
2. For Aimovig, Ajovy, and Emgality requests, please document a trial of topiramate, a tricyclic antidepressant, valproic acid, or venlafaxine. For Nurtec, Qulipta, and Vyepti requests, please document a trial of Botox, topiramate, a tricyclic antidepressant, valproic acid, or venlafaxine. Alternatively, provide clinical rationale for use of Aimovig, Ajovy, Emgality, Nurtec, Qulipta, or Vyepti instead of these agents.
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain why not. _____
3. For Nurtec, Qulipta, or Vyepti requests, please document a trial of Aimovig, Ajovy, or Emgality. Alternatively, provide clinical rationale for use of Nurtec, Qulipta, or Vyepti instead of these agents.
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain why not. _____

Section II. Please complete for Nurtec and Ubrelvy requests for acute treatment of migraine.

1. Has the member had a trial with two triptans?
   ☐ Yes. Please list the drug names, dates/duration of use, and outcomes below.*
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   Drug name _____ Dates/duration of use _____
   Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Please explain why not. _____
2. For requests for quantities above 15 units/month for Nurtec and 16 tablets/month for Ubrelvy, is the member currently receiving prophylaxis?
   ☐ Yes. Please specify.
   Drug name _____ Dose and frequency _____
   Drug name _____ Dose and frequency _____
   ☐ No. Please explain why prophylaxis is not appropriate for this member. _____
   _____

**Attach a letter with additional information regarding medication trials as applicable.*

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Section III. Please complete for recertification requests for Emgality for cluster headache.

1. Is the member still actively having a cluster headache? ☐ Yes. ☐ No.
2. Has the member been initiated on prophylactic therapy for the cluster headache?
   ☐ Yes. Please specify.
   Drug name _____ Dose and frequency _____
   Drug name _____ Dose and frequency _____
   ☐ No. Please explain why prophylaxis is not appropriate for this member. _____
   _____

Section IV. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____