



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

# 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](http://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

- |   |   |
|---|---|
| <input type="checkbox"/> Aimovig (erenumab-aooe)      | <input type="checkbox"/> Qulipta (atogepant)        |
| <input type="checkbox"/> Ajovy (fremanezumab-vfrm)    | <input type="checkbox"/> Ubrelvy (ubrogepant)       |
| <input type="checkbox"/> Emgality (galcanezumab-gnlm) | <input type="checkbox"/> Vyepti (eptinezumab-jjmr)^ |
| <input type="checkbox"/> Nurtec (rimegepant)          |   |

**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. For all requests except Nurtec, 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 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, 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, and 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. \_\_\_\_\_

4. For Qulipta requests, has the member had a trial with Nurtec?

Yes. Please list the dates/duration of use and outcomes below.

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 16 units/30 days for Nurtec and 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.*

---

**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. \_\_\_\_\_

---

**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 \_\_\_\_\_