

CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITOR
MIGRAINE PROPHYLAXIX REQUEST FORM
POLICY X.39

PREAUTHORIZATION REQUEST PRESCRIBER FAX FORM

**Only** the prescriber may complete this form for prospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Start saving time by filling out this preauthorization electronically at* MedicalPolicy.NebraskaBlue.com.

What is the priority level of this request	?					
☐ Standard review - Completed within	າ 15 calendar days of	receipt.				
Expedited/Urgent review - If the state could not be adequately managed;			jeopardize the	e life or health o	of patient	
Detient and Incurance Information	_	Tod	ay's Date: _			
Patient and Insurance Information Patient First Name:	Patient Last Name:		Middle Init	ial. Date of Birth	(mm/dd/yyyy):	
Fallerit Filot Marile.	Faucht Last Name.		Wildule ii iii	Idi. Date of Dirtin	(IIIII), uu, yyyy,	
Patient Address: City, State, ZIP		Member ID Numbe		Number:	er:	
Prescriber Information						
Prescriber Name:	Prescriber NPI:	Special	ty:	Contact Name:		
Clinic Name:	Clinic Address:			1		
City, State, ZIP: Clinic Phone Nur		mber:	Secure Fax Number:			
PLEASE ATTACH ANY ADDITION	AL INFORMATION T	HAT SHOULD BE CONS	 IDERED WITH	THIS REQUE	ST	
Requested Product and Dosage:	AL IIII OILIII III III II					
Aimovig 70mg per month Emgality 120mg per month		☐Ajovy 225mg per mon	th Uyept	i 100mg every	3 months	
Aimovig 140mg per month		Ajovy 675mg per monthOther:				
Is a loading dose required?  Diagnosis for use:					□No	
Number of headache days per month:	Number of migraine head	 lache days pei	month:			
2. Has the patient been evaluated for medi	ches?		Yes	□No		
3. Is the patient currently treated with the requested medication?					□No	
If yes, is the patient at risk if they change th			\_Yes	□No		
4. Previously tried medications (if applicable	e):					
5. Additional clinical information:						

Please fax or mail this form to:

Blue Cross and Blue Shield of Nebraska Pharmacy Department - UM PO Box 3248 Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726 Phone: 877-999-2374 **CONFIDENTIALITY NOTE:** The information contained in this facsimile message is privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by phone, and return the original message to us at the mailing address to the left.