BlueCross BlueShield Nebraska

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 15 calendar days of receipt.

☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Today's Date: _____

Patient and Insurance Information

Patient First Name:	Patient Last Name:	Middle Initial:	Date of Birth (mm/dd/yyyy):
Patient Address:	City, State, ZIP	Member ID Number:	

Prescriber Information

Prescriber Name:	Prescriber NPI:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, ZIP:	Clinic Phone Number:	Secure Fax Number:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Requested Product and Dosage:

☐ Aimovig 70mg per month ☐ Emgality 120mg per month ☐ Ajovy 225mg per month ☐ Vyepti 100mg every 3 months

☐ Aimovig 140mg per month ☐ Emgality 300mg per month ☐ Ajovy 675mg per month ☐ Other:

1. Is a loading dose required? ☐ Yes ☐ No

Diagnosis for use: _____

Number of headache days per month: _____ Number of migraine headache days per month: _____

2. Has the patient been evaluated for medication overuse headaches? ☐ Yes ☐ No

3. Is the patient currently treated with the requested medication? ☐ Yes ☐ No

If yes, is the patient at risk if they change therapy? ☐ Yes ☐ No

4. Previously tried medications (if applicable): _____

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

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