



**New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form**

Calcitonin Gene-Related Peptide (CGRP) Inhibitors for Migraine and Cluster Headache

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of migraine, with or without aura, based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria? Yes No
2. Does the patient have a diagnosis of episodic cluster headache based on ICHD-III diagnostic criteria? Yes No

(Form continues on the next page.)



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PATIENT LAST NAME:

PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (CONTINUED)

For prevention of migraine headaches, please answer questions 3–5.

3. Has medication overuse headache been ruled out by trial and failure of titrating off acute migraine treatments in the past? Yes No
4. On average, how many migraine days per month has the patient had for the past three months?
5. Has the patient tried and failed a 1-month or longer trial of any one of the following oral medications or has the patient had a contraindication to any one of the following oral medications? Yes No
- antidepressants (e.g., amitriptyline, venlafaxine)
 - beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
 - anti-epileptics (e.g., valproate, topiramate)
 - angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan)

If **yes**, please list treatment failures and provide dates:

6. **For Nurtec® ODT or Qulipta™:** Has the patient tried and failed at least one injectable CGRP? Yes No

For prevention of cluster headaches, please answer questions 7–8.

7. Have other ICHD-III headaches been ruled out? Yes No
8. Has the patient tried and failed a one-month or longer trial of any two of the following oral medications or has the patient had a contraindication to any two of the following oral medications? Yes No
- suboccipital steroid injections
 - lithium
 - verapamil
 - warfarin
 - melatonin

If **yes**, please list treatment failures and provide dates:

(Form continues on the next page.)



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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (CONTINUED)

For treatment of migraine headaches, please answer questions 9–11.

9. On average, how many migraine days per month has the patient had for the past 6 months? _____

10. Has the patient tried and failed one or more of the following:

Yes No

- non-steroidal anti-inflammatory drugs (NSAIDs)
- non-opioid analgesics
- acetaminophen
- caffeinated analgesic combination

If **yes**, please list the treatment failures and provide dates:

11. Has the patient tried and failed one or more preferred triptan? _____

Yes No

If **yes**, please list the treatment failures and provide dates:

SECTION IV: FOR RENEWALS ONLY

12. Has the patient demonstrated a significant decrease in the number, frequency, or intensity of headaches? _____

Yes No

13. Has the patient had an overall improvement in function with therapy? _____

Yes No

14. Has the patient experienced any unacceptable toxicity? _____

Yes No

Provide any additional information that would help in the decision-making process. **If additional space is needed, please use another page.**

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ DATE: _____