

## 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 MEDICATIO	N REQUESTED													
LAST NAME:	FIRST NAME:													
MEDICAID ID NUMBER:	DATE OF BIRTH:													
GENDER: Male Female														
Drug Name:	Strength:													
Dosing Directions:	Length of Therapy:													
SECTION II: PRESCRIBER INFORMATION														
LAST NAME:	FIRST NAME:													
SPECIALTY:	NPI NUMBER:													
PHONE NUMBER:	FAX NUMBER:													
SECTION III: CLINICAL HISTORY														
1. Does the patient have a diagnosis of migraine, with Classification of Headache Disorders (ICHD-III) diag														
2. Does the patient have a diagnosis of episodic cluster criteria?	er headache based on ICHD-III diagnostic Yes No													

(Form continues on the next page.)





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PATIENT LAST NAME:												F	PATIENT FIRST NAME:														
SI	SECTION III: CLINICAL HISTORY <i>(CONTINUED)</i>																										
Fo	r pre	even	tion	of	mig	rain	e he	ad	ach	es, p	oleas	se a	ns	wer	que	stior	ns 3–	5.									
3.	. Has medication overuse headache been ruled out by trial and failure of titrating off acute Yes No migraine treatments in the past?												🗌 No														
4.	On average, how many migraine days per month has the patient had for the past three months?																										
5.	For	Nur	tec	<sup>®</sup> 0[	DT o	r Qı	ulipt	a™	<b>:</b> Ha	as th	e pa	tie	nt t	ried	and	faile	ed at	leas	t one	e inje	ctab	le CG	RP?			Yes	No
Fo	r pre	even	tion	of	clus	ter l	head	lac	hes	, ple	ease	ans	swe	er qu	esti	ons	6–7.										
6.	Hav	ve ot	her	ICH	D-II	l hea	adac	he	s be	en r	ulec	lοι	ıt?												<u> </u>	Yes	🗌 No
7.	me		tion	s or										-				•			ollow ing o	ing o ral	ral		, []	Yes	🗌 No
	• • •	lith ver wa	iocc ium apa rfari lato	mil n	al st	eroi	d inj	ect	tion	S																	
	lf <b>ye</b>	es, p	leas	e li	st tr	eatr	nent	: fa	ilur	es ai	nd p	rov	ide	date	es:												

(Form continues on the next page.)





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PA	TIENT LAS	NAME		ΡΑΤ	PATIENT FIRST NAME:															
SE	SECTION III: CLINICAL HISTORY (CONTINUED)																			
For	treatmen	of mig	raine	head	ache	es, pl	ease	ansı	wer q	uestio	ns 8–	10.								
8.	On averag	e, how r	nany i	migra	aine d	days	per	mont	th ha	s the pa	atien	t had	for t	he pa	st 6 ı	nont	hs?			
	<ul><li>non-op</li><li>acetan</li></ul>	eroidal a vioid ana vinophe ated an	anti-in algesic n algesic	flam cs c con	mato nbina	ory d ation	rugs	(NSA	AIDs)		ıg:						_		] Yes	No
10.	Has the pa	tient tri	ed and	d fail	ed oi	ne or	r mo	re pr	eferr	ed tript	an?								Yes	No
	If <b>yes</b> , please list the treatment failures and provide dates:																			
SE	CTION IV:	OR REN	IEWAI	ls or	NLY															
11.	Has the p of headad		emon	strat	ed a	signi	ficar	nt de	creas	e in the	e nun	nber,	frequ	lency	, or i	nten	sity		] Yes	🗌 No
12.	Has the p	atient h	ad an	over	all in	nprov	veme	ent ir	n fund	tion w	ith th	erap	y?						Yes	🗌 No
13.	Has the p	atient e	xperie	enced	any	una	ссер	table	e toxio	city?									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:

