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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: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female **WEIGHT** in kg (pediatric patients only):_____

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 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:**

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. **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 6–7.

6. Have other ICHD-III headaches been ruled out? ☐ Yes ☐ No
7. 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 LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY *(CONTINUED)*

For treatment of migraine headaches, please answer questions 8–10.

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

9. 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:

   _____

10. 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

11. Has the patient demonstrated a significant decrease in the number, frequency, or intensity of headaches? ☐ Yes ☐ No
12. Has the patient had an overall improvement in function with therapy? ☐ Yes ☐ No
13. 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**: _____

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Fax: 1-888-603-7696

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