



**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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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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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. **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.)

