**Please select medication:**

<table>
<thead>
<tr>
<th><strong>Aimovig</strong> (erenumab-aooe)</th>
<th><strong>Ajovy</strong> (fremanezumab-vfrm)</th>
<th><strong>Emgality 120mg/mL</strong> (galcanezumab-gnim)</th>
<th><strong>Emgality 100mg/mL</strong> (galcanezumab-gnim)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLETE SECTION A</td>
<td>COMPLETE SECTION A</td>
<td>COMPLETE SECTION A</td>
<td>COMPLETE SECTION B</td>
</tr>
</tbody>
</table>

**NOTE:** Form must be completed in its entirety for processing

**Physician Completes**

**Section A:** Please answer the following questions:

a. What is the patient’s diagnosis?
   - Migraine
   - Other diagnosis (please specify): _____________________________________________________________________________

b. **Aimovig Request:** Will the patient be monitored for severe constipation?  Yes  No

c. Has the patient completed an adequate six month trial of at least ONE of the following prophylactic agents: divalproex sodium (Depakote/Depakote ER), topiramate (Topamax), amitriptyline (Elavil), venlafaxine (Effexor), or beta-blockers including: atenolol/metoprolol/propranolol/timolol/nadolol?  Yes  No

d. Does the patient have a contraindication or intolerance to at least ONE of the following Triptan agents: Amerge (naratriptan), Axert (almotriptan), Frova (frovatriptan), Maxalt (rizatriptan), Relpax (eletriptan), Imitrex (sumatriptan), or Zomig (zolmitriptan)?  Yes  No*
   *If NO, has the patient completed an adequate three month trial of at least ONE of the following Triptan agents: Amerge (naratriptan), Axert (almotriptan), Frova (frovatriptan), Maxalt (rizatriptan), Relpax (eletriptan), Imitrex (sumatriptan), or Zomig (zolmitriptan)?  Yes  No

e. Will this medication be used in combination with botulinum toxin (Botox) for the prevention of migraines?  Yes  No

f. **Aimovig or Ajovy Request:** How many injections are being requested every 90 days? __________ injection(s) per 90 days
   **Emgality Request:** How many injections are being requested every 180 days? __________ injection(s) per 180 days

**Section B:** Please answer the following questions:

a. What is the patient’s diagnosis?
   - Episodic Cluster Headaches
   - Other diagnosis (please specify): _____________________________________________________________________________

b. Does the patient have a contraindication or intolerance to at least ONE of the following: triptan agents, ergotamine tartrate, or dihydroergotamine?  Yes  No*
   *If NO, has the patient completed an adequate three month trial of at least ONE of the following: triptan agents, ergotamine tartrate, or dihydroergotamine?  Yes  No

c. How many injections are being requested every 90 days? __________ injection(s) per 90 days

---

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. CGRP – FEP CSU_MD Fax Form Revised 10/16/2020
### PHYSICIAN COMPLETES

**CONTINUATION OF THERAPY (PA RENEWAL)**

**NOTE:** Form must be completed in its entirety for processing

**Is this request for brand or generic?**
- □ Brand
- □ Generic

**How many injections are being requested every 90 days?** ________ injection(s) per 90 days

1. **Has the patient been on the medication continuously for the last 4 months, excluding samples?**
   - □ NO – this is INITIATION of therapy, please answer the questions on PAGE 1
   - □ YES – this is a PA renewal for CONTINUATION of therapy, please answer the following questions below:

2. **Will the requested medication be used in combination with another CGRP antagonist?**
   - □ Yes
   - □ No

3. **SECTION A: Please answer the following questions:**

   a. **What is the patient’s diagnosis?**
      - □ Migraine
      - □ Other diagnosis (please specify):

   b. **Aimovig Request:** Will the patient be monitored for severe constipation?
      - □ Yes
      - □ No

   c. **Has the patient had a documented decrease in migraine days from baseline or an improvement in daily activities due to the reduction of debilitating migraine?**
      - □ Yes
      - □ No

   d. **Will this medication be used in combination with botulinum toxin (Botox) for the prevention of migraines?**
      - □ Yes
      - □ No

   e. **Will the requested medication be used in combination with a Triptan agent?**
      - □ Yes*
      - □ No

   *If YES, specify drug, strength and quantity per 90 days: ______________________

**SECTION B: Please answer the following questions:**

a. **What is the patient’s diagnosis?**
   - □ Episodic Cluster Headaches
   - □ Other diagnosis (please specify):______________________________

b. **Has the patient had a decrease in frequency of cluster headache attacks?**
   - □ Yes
   - □ No

---

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. CGRP – FEP CSU_MD Fax Form Revised 10/16/2020