

## MOLINA HEALTHCARE Service Authorization (SA) Form Antimigraine Agents, Others

If the following information is not complete, correct, and legible, the SA process could be delayed.

Please use one form per member.

MEMBER INFORMATION													
Last Name:	First Name:												
Medicaid ID Number:	Date of Birth:												
Gender: Male Female	Weight in Kilograms:												
PRESCRIBER INFORMATION													
Last Name:	First Name:												
NPI Number:													
Phone Number:	Fax Number:												
DRUG INFORMATION													
Drug Name/Form:													
Strength:													
Dosing Frequency:													
Length of Therapy:													
Quantity per Day:													
	tment of migraine												
Preferred Agents *step edit required	Non-Preferred Agents (SA required)												
Aimovig®, Ajovy® and Ajovy® autoinjector Emgality® pen and syringe (120 mg), Nurtec® ODT	Emgality® syringe (100 mg) Qulipta™, Vyepti®												
	nent of migraine												
Preferred Agents (No SA with trial of 2 generic triptans)	Non-Preferred Agents (SA required)												
Nurtec® ODT, Ubrelvy™	Reyvow®, Trudhesa™, Zavzpret™												

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Molina SA Form: Antimigraine Agents, Others

Member's Last Name:								Member's First Name:														
DR	DRUG INFORMATION (Continued)																					
Ple	Please identify why the preferred agents cannot be used:																					
DIAGNOSIS AND MEDICAL INFORMATION																						
All	All drugs in this class are eligible to receive a SIX (6)-month approval. Complete the following questions.																					
For	For Preventive treatment of migraine, does the member meet the *step edit AND the following criteria?																					
1.	<ol> <li>Does the member have a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria? AND</li> </ol>																					
	Yes No																					
2. I	2. Is the member ≥ 18 years of age? AND																					
	Y	es		No																		
3.	<ul><li>3. Has the member had ≥ 4 migraine days per month for at least 3 months? AND</li><li>Yes  No</li></ul>																					
4.	*Has	the	mem	hber tri	ed and	d faile	ed a ≥	1 mor	th tri	al c	of any	2 of	the	follov	wing	oral	gene	ric m	edica	ation	s?	
	<ul> <li>4. *Has the member tried and failed a ≥ 1 month trial of any 2 of the following oral generic medications?</li> <li>Antidepressants (e.g., amitriptyline, venlafaxine)</li> <li>Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)</li> <li>Anti-epileptics (e.g., valproate, topiramate)</li> <li>Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan)</li> <li>Yes No</li> </ul>											an)										
For	rene	wal,	com	plete t	he foll	lowin	g qu	estion	to rec	eiv	e a T	WEL	VE (1	2)-m	onth	арр	roval					
1. <b>Me</b>	<ol> <li>Did the member demonstrate significant decrease in the number, frequency, or intensity of headaches?</li> <li>Yes No</li> <li>Member's Last Name:</li> <li>Member's First Name:</li> </ol>																					
	r Acı teria		reat	ment (	of mig	grain	e, d	oes th	e me	_ em∣	ber r	nee	t the	*ste	ep ed	dit A	ND t	he f	ollo	wing	 }	
1.	Does	s the	men	nber ha	ve a d	liagno	osis c	of migra	aine w	/ith	or wi	thou	t aur	a? <b>A</b> l	ND							
	Y	es		No																		
2.	Is the	e me	mbe	r ≥ 18 y	ears o	of age	? <b>AN</b>	ND														
	☐ Yes ☐ No																					
(Fo	(Form continued on next page.)																					

## Molina SA Form: Antimigraine Agents, Others

3.	*Has the member tried and failed (or has contraindications to) two preferred triptan medications?																					
	Yes		No																			
4.	Prior to initiation of Trudhesa™, a cardiovascular evaluation is recommended. Has this been completed?																					
	Yes		No																			
Foi	renew	al, com	plete t	the follo	owin	g qu	estic	on to	rec	eiv	e a T\	WELV	/E (1	2)-m	onth	арр	rova	I.				
			_										-	-					of he	adac	hes?	)
<ol> <li>Did the member demonstrate significant decrease in the number, frequency, or intensity of headach</li> <li>Yes</li> <li>No</li> </ol>																						
			1																			
Μe	Member's Last Name: Member's First Name:																					
Foi	For Episodic Cluster Headache, does the member meet the following criteria?																					
1.	. Does the member have a diagnosis of episodic cluster headache? <b>AND</b>																					
	Yes No																					
2.	. Is the member ≥ 18 years of age? AND																					
	Yes No																					
3.			-	perience sting at					-			sting	fron	n 7 d	ays t	o 36	5 day	rs, se	para	ted b	У	
	Yes		No																			
4.				be used tment o						anc	ther	CGR	P ant	tagor	nist o	r inh	ibito	r use	d fo	•		
	Yes		No																			
5.				ed and f acologic		•							at le	ast o	ne st	anda	ard p	roph	ylact	ic		
	Yes		No																			
Foi	renew	al, com	plete t	the follo	owin	g qu	estic	on to	rec	eiv	e a T\	WELV	/E (1	2)-m	onth	арр	rova	l.				
1. Did the member demonstrate significant decrease in the number, frequency, or intensity of heada											adac	hesi	)									
	Yes		] No																			
Pr	escribe	r Signa	ature (	(Requir	ed)											Da	ite					

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by Molina Healthcare

The completed form may be **FAXED** to **(844) 278-5731**, or you may call **(800) 424-4518** (TTY:711)