Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Calcitonin Gene-Related Peptide (CGRP) Inhibitors– Medical Necessity Request

Complete page 1&2 for Initial Requests Only*

1. How many headache days per month does the member have? _____ ***Please submit chart documentation***.
2. How long has the member experienced the headaches? _____
3. Is the medication being used for migraines?
   - □ No
   - □ Yes – Is it being used for the prevention or treatment of migraines? □ Prevention □ Treatment
     - Please indicate whether the member has an aura with the migraine, then indicate <u>all</u> associated symptoms/features the member has, and the number of days per month the symptoms are experienced:

Aura Status	Symptom/Feature	No. of days/month experienced
□ Migraine <u>without</u> aura	□ unilateral location □ pulsating quality □ moderate or severe pain intensity □ aggravation by or causing avoidance of routine physical activity (e.g., walking or climbing stairs) □ nausea and/or vomiting during the headache □ photophobia and phonophobia during the headache	_____ _____ _____ _____ _____ _____
□ Migraine <u>with</u> aura	□ visual □ sensory □ speech and/or language □ motor □ brainstem □ retinal □ at least one aura symptom spreads gradually over ≥5 min □ two or more aura symptoms occur in succession □ each individual aura symptom lasts 5-60 minutes □ at least one aura symptom is unilateral □ at least one aura symptom is positive □ aura is accompanied, or followed within 60 min, by headache	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

4. Does the member have cluster headaches?
   - □ No – Proceed to Question #5
   - □ Yes
     - Does the member have a minimum of 1 attack every other day? **Yes or No**
     - Has the member had at least 5 attacks with the following signs and/or symptoms? *Please indicate all symptoms experienced.* **Yes or No**
       - □ A sense of restlessness or agitation
       - □ Conjunctival injection and/or lacrimation on same side as headache
       - □ Nasal congestion and/or rhinorrhea on same side as headache
       - □ Eyelid oedema on same side as headache
       - □ Forehead and facial sweating on same side as headache
       - □ Miosis and/or ptosis on same side as headache
     - Have the attacks spanned a time period of at least 7 days to 1 year? **Yes or No**
     - Have the pain-free remission periods between the attacks lasted at least 3 months? **Yes or No**

Continued on p. 2

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

5. Does the member have a medication-overuse headache (aka drug-induced headache, medication-misuse headache, rebound headache)?

□ No – Proceed to Question #7

□ Yes

- What medication(s) is causing the headache? _____
- How many days per month does the member take this medication? _____
- How long has the member been taking this medication? _____
- Does the member continue to have migraines despite discontinuing the overuse of drugs taken for acute and/or symptomatic treatment of headaches? □ Yes □ No

6. What other drugs will the member be receiving with the requested drug?

_____

7. Please document all medications the member has used for the given diagnosis, strength, trial dates and discontinuation reasons. *Please also submit documentation of fills*

Drug Name	Strength	Directions	Dates Tried	Discontinuation Reason

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

****Complete page 3 only for Subsequent/Renewal requests****

For Chronic or Episodic Migraines, please complete the following questions:

1. Is the medication being used for the prevention or treatment of migraines? □ Prevention □ Treatment

2. Has the member had improvement in migraine prevention? □ Yes □ No

3. What other drugs will the member be receiving with the requested drug?

_____

For Episodic Cluster Headaches, please complete the following questions.

1. Has the member had a reduction in the frequency of cluster headache attacks? □ Yes □ No

2. What other drugs will the member be receiving with the requested drug?

_____

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**