DisclosedRx
The Fiduciary and Fully Disclosed PBM®

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Prior Authorization Request Form

CGRP Antagonists (Acute & Prophylaxis)

☐Standard ☐Urgent ☐Reconsideration/Appeal

Patient Information

Patient Name: _____ DOB (mm/dd/yyyy): _____ Gender: _____

Address: _____ City: _____ State & Zip: _____

Cardholder ID: _____ Group #: _____ Relationship Code: _____

Phone Number: _____ Email address: _____

Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State & Zip: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

Medication Information

Drug Name: _____ Strength: _____ Quantity: _____

Directions: _____ Day Supply: _____

Indicate Request Type: ☐New Start ☐Renewal Therapy Start Date (if applicable): _____

Diagnosis: _____ ICD 10 Code: _____

Prior Authorization Request Information

Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays*

For all requests:

1. Does the patient have any FDA contraindications to the requested agent? ☐Yes ☐No
2. Will the patient be taking any other medications in combination with the requested agent for the treatment of this diagnosis? If yes, please list: _____ ☐Yes ☐No

For Acute Treatment Requests:

3. Has medication overuse headache been ruled out? ☐Yes ☐No
4. Will the patient be taking the requested agent in combination with another ACUTE migraine therapy (i.e., another triptan, acute use CGRP, ergotamine)? ☐Yes ☐No
5. Has the patient had an inadequate clinical response, intolerance, or contraindication to at least TWO triptan agents? If yes, please list below. ☐Yes ☐No

Drug Name/Strength:	Start Date:	End Date:	Outcome:

Please continue to the next page.

Patient Name:	DOB:

For Prophylaxis Requests:

6. **On average, how many migraine days has the patient had per month over the past 3 months? _____**
7. **On average, how many headache days has the patient had per month over the past 3 months? _____**
8. **Has the patient experienced any of the following?**
   - ☐ **More than 4 migraines per month**
   - ☐ **Acute therapies are contraindicated**
   - ☐ **Migraines lasting longer than 12 hours**
   - ☐ **Experiences severe disability or reduced quality of life due to migraines**
9. **Will the patient be taking the requested agent in combination with another PROPHYLACTIC CGRP antagonist?** ☐ **Yes** ☐ **No**
10. **Does the patient must an inadequate clinical response, intolerance, or contraindication to at least an 8-week supply of TWO migraine prophylactic agents (anticonvulsants: divalproex, valproic acid, topiramate); beta blockers: atenolol, metoprolol, nadolol, propranolol, timolol; antidepressants: amitriptyline, venlafaxine)? If yes, please list below.** ☐ **Yes** ☐ **No**

Drug Name/Strength:	Start Date:	End Date:	Outcome:

For Cluster Headache Requests:

11. **Will the patient be taking the requested agent in combination with another CGRP antagonist?** ☐ **Yes** ☐ **No**
12. **Does the patient must an inadequate clinical response, intolerance, or contraindication to verapamil is defined as a titration to at least 480mg daily? If yes, please list below.** ☐ **Yes** ☐ **No**

Drug Name/Strength:	Start Date:	End Date:	Outcome:

For Renewal Requests:

13. **Has the patient had a positive clinical response to therapy as evidenced by a reduction in migraine duration, frequency, and severity? Must submit objective documentation.** ☐ **Yes** ☐ **No**
14. **Does the patient have any FDA contraindications to the requested agent?** ☐ **Yes** ☐ **No**
15. **Will the patient be taking the requested agent in combination with another CGRP antagonist for the same indication? If yes, please list: _____** ☐ **Yes** ☐ **No**

Prescriber Signature: _____ **Date: _____**

Authorized Agent's Name: _____

Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com
Mail Requests to: DisclosedRx Clinical Team
PO Box 701 Washington, IN 47501

Additional Comments/Notes: