OKLAHOMA Health Care Authority

# State of Oklahoma SoonerCare Qulipta™ (Atogepant) Prior Authorization Form

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**Member Name:________________________ Date of Birth:______________ Member ID#:_________________**

## Drug Information

***Pharmacy billing (NDC:_________________ ) Start Date (or date of next dose):________________________***

***Dose: ________________ Regimen:__________________________ Fill Quantity:________ Day Supply:_____***

## Pharmacy Information

***Pharmacy NPI:______________________________ Pharmacy Name:__________________________________***

***Pharmacy Phone:___________________________ Pharmacy Fax:_____________________________________***

## Prescriber Information

***Prescriber NPI:________________________ Prescriber Name:_____________________________________***

***Prescriber Phone:_________________ Prescriber Fax:________________ Specialty:__________________***

## Criteria

**All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.**

***Page 1 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays.****

**For Initial Authorization (Initial approval will be for the duration of 3 months):**

1. What is the member's diagnosis?
   - ☐ Preventive treatment of migraines in adults
   - ☐ Other, please list:_______________________________________________
2. Does the member have documented:
   - ☐ Episodic Migraine Headache
   - ☐ Chronic Migraine Headache
   - ☐ Other, please list:_______________________________________________
3. Date of member's migraine diagnosis?_____________
4. Number of headache days per month?________
5. Number of migraine days per month (if episodic migraine, number of days on average for the past 3 months)?________
6. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated?
   a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes ☐ No ☐
   b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes ☐ No ☐
7. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated?
   a. Hormone replacement therapy or hormone-based contraceptives? Yes ☐ No ☐
   b. Chronic insomnia? Yes ☐ No ☐
   c. Obstructive sleep apnea? Yes ☐ No ☐
8. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc.)? Yes ☐ No ☐ If yes, please list:
   Medication____________________________ Date Span________________ Dosing_________________________
   Medication____________________________ Date Span________________ Dosing_________________________
   Medication____________________________ Date Span________________ Dosing_________________________
9. If the trial duration for the medication(s) listed above is not at least 8 weeks, please document the reason(s):
   Medication(s)______________________________________________________
   Reason(s) for discontinuation prior to 8 weeks: _______________________________________________



| Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.** | CONFIDENTIALITY NOTICE<br><br>*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.* |
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# Qulipta™ (Atogepant) Prior Authorization Form

**Member Name:____________________ Date of Birth:_____________ Member ID#:____________________**

## Criteria

**All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.**



**For Initial Authorization (continued):**

10. Is the member taking any of the following medications **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain?
    a. Decongestants (alone or in combination products)? Yes☐ No☐
    b. Combination analgesics containing caffeine and/or butalbital? Yes☐ No☐
    c. Opioid-containing medications? Yes☐ No☐
    d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes☐ No☐
    e. Ergotamine-containing medications? Yes☐ No☐
    f. Triptans? Yes☐ No☐
11. Is the member taking any of the medications, listed in Question 10, **known** to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain? Yes☐ No☐
    a. If yes, to any of the medication(s) listed in Question 10, please list the medication(s) and the number of days per month taken:____________________________________________
    ____________________________________________
    b. If yes, to any of the medication(s) listed in Question 10, please provide additional information to support member's need for continued use of medication(s) known to cause overuse or rebound headaches:
    ____________________________________________
    ____________________________________________
12. Is the member taking any medications that are **likely** to be the cause of the headaches? Yes☐ No☐
13. Has the member been evaluated within the last 6 months by a neurologist for migraine headaches and was Qulipta™ recommended as treatment? Yes☐ No☐
    a. If yes, please include name of neurologist recommending Qulipta™ treatment______________________
14. Will member use Qulipta™ concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor? Yes☐ No☐
15. If applicable, are other aggravating factors that contribute to the development of episodic/chronic migraine headaches being treated (e.g., smoking)? Yes☐ No☐ Not Applicable☐
16. Please provide a patient-specific, clinically significant reason why the member cannot use Aimovig® (erenumab-aooe), Emgality® (galcanezumab-gnlm) or Ajovy® (fremanezumab-vfrm):
    ____________________________________________
    ____________________________________________

**Additional Information:**____________________________________________

**For Continued Authorization (Compliance and information regarding efficacy will be required for continued approval):**

1. Has the member been compliant with Qulipta™ (atogepant) treatment? Yes☐ No☐
2. Has the member responded well to treatment with Qulipta™ (atogepant)? Yes☐ No☐
3. Please provide the member's current number of migraine days per month:__________

**Additional Information:**____________________________________________

**Prescriber Signature:______________________________ Date:____________________**

***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.***

*Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

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