OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Ajovy® (fremanezumab-vfrm) Prior Authorization Form

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

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

1. What is the member's diagnosis?
   - ❑ Preventive treatment of migraines
   - ❑ Other, please list:____
2. Does the member have documented:
   - ❑ Chronic Migraine Headache
   - ❑ Episodic Migraine Headache
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. Has the member been evaluated for all of the following, as defined by the American Headache Society, and these conditions have been ruled out and/or treated:
   a. Red flags? Yes____ No____
   b. Possible indicators of secondary headache? Yes____ No____
   c. Medication overuse? Yes____ No____
7. Will member use Ajovy® concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor? Yes____ No____
8. Has the member been counseled on appropriate use, administration technique, and storage of Ajovy®? Yes____ No____
9. If member is under 18 years of age, please provide a recent weight: _______(kg)

For Continued Authorization:

1. Has the member been compliant with Ajovy® treatment? Yes____ No____
2. Has the member responded well to treatment with Ajovy®? 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.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*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.*