OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

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## Emgality® Prior Authorization Request Form (Page 1 of 2) DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)			
Member Name:			Provider Name:			
Insurance ID#:			NPI#:	NPI#: Specialty		
Date of Birth:			Office Phone:			
Street Address:			Office Fax:			
City:	State:	ZIP:	Office Street Address:			
Phone:		City:	State: ZIF		P:	
		Medication In	formation (require	ad)		
Medication Name:			Strength:	Dosage Form:		:
			Directions for Use:			
		Clinical Info	ormation (required)			
Initial Authorization	on:					
Does the patient have a diagnosis of episodic migraines?						☐ Yes ☐ No
2. Does the patient have four to 14 migraine days per month, but no more than 14 headache days per month?					□ Yes □ No	
3. Does the patient have a diagnosis of chronic migraines?						☐ Yes ☐ No
	have greater than e days for at least	or equal to 15 headac three months?	he days per month, of	which at lea	ast eight	☐ Yes ☐ No
5. Has medication overuse headache been considered and have potentially offending medication(s) been discontinued?						☐ Yes ☐ No
6. Does the patient have a diagnosis of episodic cluster headache?						☐ Yes ☐ No
	experienced at leas iods lasting at least	t two cluster periods la t three months?	asting from seven days	to 365 day	s, separated	□ Yes □ No
8. Does the patient have a history of failure (after at least a two-month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine)?						☐ Yes ☐ No
9. Does the patient have a contraindication to BOTH Elavil (amitriptyline) and Effexor (venlafaxine)?						☐ Yes ☐ No
10. Does the patient have a history of failure (after at least a two-month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)?						□ Yes □ No
11. Does the patient have a contraindication to BOTH Depakote/Depakote ER (divalproex sodium) and Topamax (topiramate)?					☐ Yes ☐ No	
12. Does the patient have a history of failure (after at least a two-month trial) or intolerance to ONE of the following beta blockers: atenolol, propranolol, nadolol, timolol or metoprolol?						□ Yes □ No
13. Does the patient have a contraindication to ALL of the following beta blockers: atenolol, propranolol, nadolol, timolol and metoprolol?						☐ Yes ☐ No

This document – and others if attached – contains information that is privileged, confidential and/or may contain protected health information (PHI). The provider named above is required by applicable law to safeguard PHI. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.

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## Emgality® Prior Authorization Request Form (Page 2 of 2)

Reauthorization:				
Has the patient experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity?				
2. Has the use of acute migraine medications (e.g., NSAIDs, triptans) decreased since the start of CGRP therapy?				
3. For chronic migraine, does the patient continue to be monitored for medication overuse headache (MOH)?				
Information on this form is accurate as of this date.				
Prescriber's Signature:	ate:			
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information this review?	the physician feels is important to			

For more information about the prior authorization process, please contact us at 855-811-2218. Monday - Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern