OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Qulipta™ (Atogepant) 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

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. Has the member been evaluated for red flags or possible indicators of secondary headache, as defined by the American Headache Society, and these conditions have been ruled out and/or have been treated? 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: _____

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.*

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Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Criteria

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

For Initial Authorization (continued):

10. Is the member taking any of the following medications **known** to cause medication overuse or rebound headaches?
    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. If the member is taking any of the medications, listed in Question 10 please answer the following:
    a. List the medication(s) and the number of days per month taken: _____
    _____
    b. Are they taking the medication for an intractable condition known to cause chronic pain? Yes☐ No☐
        i. If yes, please provide the condition being treated: _____
        ii. If no, 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. 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☐
14. 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☐
15. 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: _____

Please complete and return all pages. Failure to complete all pages will result in processing delays.

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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