Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

CGRP Inhibitors (Aimovig, Ajovy, Emgality)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Aimovig 70mg ☐ Aimovig 140mg
☐ Ajovy 225mg ☐ Ajovy 225mg/1.5ml autoinjector
☐ Emgality 100mg syringe ☐ Emgality 120mg pen ☐ Emgality 120mg syringe
☐ other (please specify):

Dosing and Quantity: Duration of therapy:

Frequency of administration: ICD10:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

(if continued therapy) Has your patient had a reduction in monthly migraine days or hours? ☐ Yes ☐ No
(if continued therapy) Has your patient had a reduction in days requiring acute migraine-specific treatment? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information

PRIOR to the requested drug, how many HEADACHE days per month is/was your patient experiencing? _____
PRIOR to the requested drug, how many MIGRAINE days per month is/was your patient experiencing? _____

(if Emgality) Is this drug being used for the treatment of cluster headache (defined as occurring with a frequency between one headache every other day and eight headaches per day)? ☐ Yes ☐ No
(if Aimovig, Ajovy or Emgality and NOT for cluster headache) Is the drug requested being used for preventative treatment of migraine headaches? ☐ Yes ☐ No
(if not for preventative treatment of migraines) What is the diagnosis related to use? _____

While taking the requested drug, will your patient receive any other CGRP inhibitors indicated for the preventative treatment of migraine (Aimovig, Ajovy, Emgality, Vyepti) during the same time period? ☐ Yes ☐ No
(if yes) Please explain and provide clinical rationale for concurrent use of these drugs.

While taking the requested drug, will you patient also receive Botox during the same time? ☐ Yes ☐ No

(if yes) Is the requested drug being used for preventative treatment of CHRONIC migraine headaches? ☐ Yes ☐ No

(if for preventative treatment of chronic migraine) Is/Was your patient continuing to experience 4 or more migraine headache days per month after therapy with ONE of the following?

☐ Yes, after a minimum 6 month trial (2 injection cycles) of Botox
☐ Yes, after a minimum 3 month trial of Aimovig, Ajovy, Emgality, or Vyepti
☐ None of the above

(if Aimovig, Ajovy, or Emgality migraine) Has your patient been treated in the past with any of the following? (check all that apply)
☐ antiepileptic drugs (divalproex, sodium valproate, topiramate)
☐ antidepressants (amitriptyline, venlafaxine)
☐ beta blockers (metoprolol, propranolol, timolol)
☐ Botox
☐ none of the above
(if yes) Please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug checked. _____

(if Aimovig, Ajovy, or Emgality migraine) Is there a documented contraindication per FDA label (or inability to use for Botox only) OR reason your patient is not a candidate for any of the following? (check all that apply):
☐ antiepileptic drugs (divalproex, sodium valproate, topiramate)
☐ antidepressants (amitriptyline, venlafaxine)
☐ beta blockers (metoprolol, propranolol, timolol)
☐ Botox
☐ none of the above
(if yes) Please include drug name and the documented reasons your patient is unable to use that drug/drug class._____

(if Ajovy or Emgality with migraine) Has your patient tried Aimovig? Yes ☐ No ☐
(if tried Aimovig) Please provide the following details: drug name, date(s) taken and for how long, and what the documented results were of taking the drug, including any documented intolerances or adverse reactions your patient experienced.
_____

(if not tried) Is your patient able to try Aimovig? Yes ☐ No ☐
(if no) Please list all documented inability or contraindication(s) per FDA label that your patient has to using Aimovig, including any reason(s) they are not a candidate to try it. _____

(if cluster headache, Emgality) Is there documentation your patient has tried and had failure/inadequate response OR intolerance to EITHER of the following? Check those that apply.
☐ injectable sumatriptan (generic Imitrex)
☐ zolmitriptan nasal spray (generic Zomig)
(if yes) Please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug tried._____

(if cluster headache, Emgality) Is there documentation your patient has a contraindication per FDA label or is not a candidate to EITHER of the following? Check those that apply.
☐ injectable sumatriptan (generic Imitrex)
☐ zolmitriptan nasal spray (generic Zomig)
(if no) Please list all documented contraindication(s) per FDA label and/or any reasons your patient is not a candidate to the drugs checked above.

Additional Pertinent Information: *Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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