

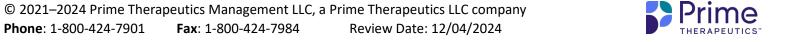
New Hampshire AIDS Drug Assistance Program Prior Authorization Drug Approval Form

Calcitonin Gene-Related Peptide (CGRP) Inhibitors for Migraine and Cluster Headache

DATE OF MEDICATION REQUEST: / /

SE	CTI	ON	I: P	ATIE	NT I	NFO	RMA ⁻	ΓΙΟΝ	ANE) ME	DICA	TION	l R	EQUE	STED)												
LA	LAST NAME:													FIRS	ΓΝΑΙ	ME:												
MEDICAID ID NUMBER:												DATE OF BIRTH:																
															_			_										
GE	GENDER: Male Female															1		_										
Dr	Drug Name: Strength:																											
Do	Posing Directions: Length of Therapy															/ :												
SE	SECTION II: PRESCRIBER INFORMATION																											
LA	LAST NAME:													FIRST NAME:														
SP	SPECIALTY: NPI NUMBER:														1	l	1											
PH	ON	ΕN	UM	BER:										FAX	NUM	BER	:	I		· I		_I	<u> </u>	_				
				-				-																				
SE	CTIC	NC	III: C	CLIN	ICAL	HIST	ΓORY																					
1.			-				_			_				withc			oase	d on	Inter	natio	nal		Ye	es [No			
2.	Do crit		•	atie	nt h	ave a	a diag	nosis	of e	piso	dic c	luste	r h	eadad	he ba	ased	on I	CHD-	III dia	agnos	stic		Ye	es [No			
Fo	pre	eve	ntio	n of	mig	raine	e hea	dach	es, p	leas	e ans	wer	qu	estio	ıs 3–	5.												
3.							e hea the p		e be	en ru	ıled (out b	y tı	rial ar	d fail	lure	of tit	ratin	g off	acut	e		Ye	es	☐ No			
4.	On mo		_	e, ho	ow n	nany	migr	aine	days	per	mon	th ha	s tl	ne pa	tient	had	for t	he pa	st th	ree								
5.	For	·Νι	ırte	® O	DT o	r Qu	lipta™	⁴: Ha	s the	pati	ient 1	tried	an	d faile	d at	least	one	inje	ctable	e CGI	RP?		Ye	s [No			

(Form continues on the next page.)





New Hampshire AIDS Drug Assistance Program Prior Authorization Drug Approval Form

Calcitonin Gene-Related Peptide (CGRP) Inhibitors for Migraine and Cluster Headache

DATE OF MEDICATION REQUEST: / /

PA	PATIENT LAST NAME: PA														PATIENT FIRST NAME:											
SE	SECTION III: CLINICAL HISTORY (CONTINUED)																									
For	prev	ention	of c	luste	r head	ache	s, ple	ase a	answ	er qu	ıest	tions	6–7.													
6.	Have	other	ICHE	-III h	eadach	nes b	een r	uled	out?	•												Yes	☐ No			
7.	mediomediomediomediomediomediomediomedio	cation cation	s or h s? ipital mil mil	nas th	and fa ie patio	ent h	iad a							•				_	oral			Yes	No			
For	treat	ment	of m	igrair	ne hea	dach	es, pi	lease	ansı	wer q	que.				for t	he n	ast 6	mon	ıths?							
		_					•	•				•														
	 9. Has the patient tried and failed one or more of the following: non-steroidal anti-inflammatory drugs (NSAIDs) non-opioid analgesics acetaminophen caffeinated analgesic combination 															<u> </u>	'es	∐ No								
	ır yes	, pieas	se iist	tne	treatm	enti	allure	es an	a pro	ovide	ua	ies:														
10.	Has t	he pat	ient	tried	and fa	iled (one o	r mo	re pr	eferr	ed	tripta	an?								Y	'es	☐ No			
	If yes	, pleas	se list	the t	treatm	ent f	ailure	es an	d pro	ovide	da	tes:														
(Fo	rm co	ntinue	es on	the n	ext pa	ae.)																				

Phone: 1-800-424-7901 **Fax**: 1-800-424-7984





New Hampshire AIDS Drug Assistance Program Prior Authorization Drug Approval Form

Calcitonin Gene-Related Peptide (CGRP) Inhibitors for Migraine and Cluster Headache

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:													PATIENT FIRST NAME:											
SEC	SECTION IV: FOR RENEWALS ONLY																							
11.	1. Has the patient demonstrated a significant decrease in the number, frequency, or intensity Yes No of headaches?															No								
12. Has the patient had an overall improvement in function with therapy?																Yes	; [No						
13. Has the patient experienced any unacceptable toxicity?															; [No								
	Provide any additional information that would help in the decision-making process. If additional space is needed, please use another page.															ed,								
I ce	rtify t	that	the i	inform	natio	n pr	ovid	ed is	accu	rate	and	con	nple	te to	the	best	of m	y kno	wled	lge a	nd I ເ	ındeı	stan	ıd
tha	t any	fals	ificat	ion, (omiss	sion,	or c	once	alme	nt o	f mat	eria	al fa	ct m	ay su	bject	t me	to civ	il or	crimi	nal li	abilit	:y.	
PRE	PRESCRIBER'S SIGNATURE: DATE:																							

Phone: 1-800-424-7901 **Fax**: 1-800-424-7984

