Washington State Department of Labor & Industries

Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonist for Treatment of Chronic Migraine

Office of the Medical Director
PO Box 44321
Olympia WA 98504-4321

Please fax completed form, along with any supportive medical documentation, to: 360-902-6315.

Claim Number	Injured Worker's Name

Section 1

Is this the initial request? ☐ Yes — Go to Section 2 ☐ No — Go to Section 3

Section 2

Criteria for initial course (all of the following must be met):

1. Is the chronic migraine diagnosis causally related to the industrial injury or occupational disease? ☐ Yes ☐ No
2. Has the worker kept a daily headache diary for ≥ 3 months noting the frequency, duration and quality of headaches? ☐ Yes ☐ No
   If "Yes", **submit a copy** with this form.
3. Does the worker meet the International Headache Society's diagnostic criteria for chronic migraine (headache on ≥ 15 days per month for > 3 months, which has migraine features on ≥ 8 days per month)? ☐ Yes ☐ No
4. Has the worker tried ≥ 3 prophylaxis drugs from ≥ 2 different classes? ☐ Yes ☐ No

Anticonvulsants	**Antidepressants**	**Beta-blockers**
divalproex sodium/valproate	amitriptyline	metoprolol
topiramate	venlafaxine	propranolol
		timolol

If "Yes", **specify**:

Drug #1:	Date:	Outcome:
Drug #2:	Date:	Outcome:
Drug #3:	Date:	Outcome:

5. Is drug therapy being managed to avoid medication overuse headaches (no use of triptans for 10 or more days per month, and/or use of analgesic for 15 or more days per month? ☐ Yes ☐ No
6. Is use of CGRP part of an agreed upon, time-limited, rehabilitative treatment plan? ☐ Yes ☐ No

If "Yes", **specify**:

Section 3

Criteria for continued coverage (all of the following must be met):

1. Was the CGRP receptor antagonist well-tolerated during the 90-day trial? ☐ Yes ☐ No
2. Did drug trial result in ≥ 50% reduction in headache days per month from baseline? ☐ Yes ☐ No
   If "Yes", submit a copy of headache diary with this form.
3. Did the drug trial result in rehabilitative benefit (e.g. participation in vocational rehabilitation or return to work)? ☐ Yes ☐ No

If "Yes", **specify**:

Section 4

Prescriber Name	Prescriber Phone Number
Signature	Date

 RESET Index: **RQST**