MIGRAINE ACUTE TREATMENT AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Migraine Acute Treatment Agents** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength & dosage form:	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Please complete either the INITIAL requests or RENEWAL requests section. If the requested prescription exceeds the quantity limits/daily dose limits, also complete the QUANTITY LIMITS/DAILY DOSE LIMITS section. Please refer to the the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html for applicable limits.

INITIAL requests

Check all of the following that apply to the member and this request and SUBMIT DOCUMENTATION for each item.
Refer to https://papdl.com/preferred-drug-list for a list of preferred & non-preferred drugs in the Migraine Acute Treatment Agents class.

1. For a GEPANT / SMALL MOLECULE CGRP INHIBITOR for the acute treatment of migraine (e.g., Nurtec ODT, Ubrelvy)

☐Tried and failed at least 2 TRIPTANS (e.g., rizatriptan, sumatriptan, etc.) or has a contraindication or an intolerance to TRIPTANS

☐**For a NON-PREFERRED GEPANT:**
- ☐ Tried and failed or has a contraindication or an intolerance to the preferred GEPANTS

2. For a DITAN / 5HT1 RECEPTOR AGONIST (e.g., Reyvow):

☐Tried and failed or has a contraindication or intolerance to the preferred TRIPTANS

☐**For a NON-PREFERRED DITAN:**
- ☐Tried and failed or has a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents

3. For an ERGOT ALKALOID (e.g., Cafergot, D.H.E., Migranal, etc.)

☐Tried and failed or has a contraindication or intolerance to the following abortive drugs:
- ☐caffeine/analgesic combination (e.g., Excedrin)
- ☐NSAIDs
- ☐triptans
- ☐a combination of an NSAID with a triptan

☐ other: _____

☐ **For a NON-PREFERRED ERGOT ALKALOID:**
- ☐ Tried and failed or has a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents

4. For a NON-PREFERRED TRIPTAN:

☐ Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS

5. For a NON-PREFERRED NSAID (e.g., Elyxyb, diclofenac powder packet):

☐ Tried and failed or has a contraindication or an intolerance to the preferred oral NSAIDs in the NSAIDs PDL class

6. For a NON-PREFERRED TRIPTAN-NSAID COMBINATION PRODUCT (e.g., sumatriptan-naproxen, Symbravo):

☐ Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS
☐ Has a clinical reason why the INDIVIDUAL ACTIVE INGREDIENTS of the requested drug cannot be used concurrently

☐ **Also, for SYMBRAVO (meloxicam-rizatriptan):**
- ☐ Tried and failed or has a contraindication or an intolerance to SUMATRIPTAN-NAPROXEN tablet

7. For ALL OTHER NON-PREFERRED Migraine Acute Treatment Agents:

☐ Tried and failed or has a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents

RENEWAL requests

Check all of the following that apply to the member and this request and SUBMIT DOCUMENTATION for each item.
Refer to https://papdl.com/preferred-drug-list for a list of preferred & non-preferred drugs in the Migraine Acute Treatment Agents class.

1. For ALL requests:

☐ Experienced improvement in headache pain, symptoms, or duration

2. For a NON-PREFERRED TRIPTAN:

☐ Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS

3. For a GEPANT / SMALL MOLECULE CGRP INHIBITOR (e.g., Nurtec ODT, Ubrelvy)

☐ Tried and failed or has a contraindication or intolerance to the preferred GEPANTS

4. For a NON-PREFERRED NSAID (e.g., Elyxyb, diclofenac powder packet):

☐ Tried and failed or has a contraindication or an intolerance to the preferred oral NSAIDs in the NSAIDs PDL class

5. For a NON-PREFERRED TRIPTAN-NSAID COMBINATION PRODUCT (e.g., sumatriptan-naproxen, Symbravo):

☐ Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS
☐ Has a clinical reason why the INDIVIDUAL ACTIVE INGREDIENTS of the requested drug cannot be used concurrently

☐ **Also, for SYMBRAVO (meloxicam-rizatriptan):**
- ☐ Tried and failed or has a contraindication or an intolerance to SUMATRIPTAN-NAPROXEN tablet

6. For ALL OTHER non-preferred Migraine Acute Treatment Agents:

☐ Tried and failed or has a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents

QUANTITY LIMITS/DAILY DOSE LIMITS requests

All requests that exceed the quantity limits/daily dose limits established by DHS require prior authorization.
Please refer to the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html for applicable limits.

Is the requested medication prescribed by a neurologist or specialist certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)?	☐Yes ☐No
Is the requested quantity/dose/frequency supported by current medical compendia and/or peer-reviewed medical literature?	☐Yes ☐No *Submit documentation.*

For ACUTE TREATMENT OF MIGRAINE, check all that apply to the member and this request and SUBMIT DOCUMENTATION for each:

☐Was evaluated for the overuse of abortive headache medications (e.g., opioids, triptans, butalbital, etc.)

☐Will be using the requested medication with at least one medication for migraine prevention – specify:

- ☐anticonvulsant (e.g., topiramate, valproate derivative)
- ☐antidepressant (e.g., SNRI, TCA)
- ☐other: _____
- ☐beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)

☐Tried and failed preventive migraine medications – specify:

- ☐anticonvulsant (e.g., topiramate, valproate derivative)
- ☐antidepressant (e.g., SNRI, TCA)
- ☐other: _____
- ☐beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)

☐Has an intolerance or a contraindication to preventive migraine medications – specify:

- ☐anticonvulsant (e.g., topiramate, valproate derivative)
- ☐antidepressant (e.g., SNRI, TCA)
- ☐other: _____
- ☐beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)