Prior Authorization Request Form for Migraine Prevention Agent

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/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have a history of contraindication to the prescribed medication?	☐ Yes ☐ No
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Migraine Prevention Agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No Medications Previously Taken (start and end date and dose):_____ [redacted]

- ☐ If not prescribed by one of the following specialist neurologist or headache specialist (certified in headache medicine but the United Council for Neurological Subspecialties (UCNS)), please indicate a specialist consulted:_____
- ☐ Will discontinue use of Migraine Prevention Agent prior to starting the requested Migraine Prevention Agent **OR**
- ☐ Has a medical reason for concomitant use of both Migraine Prevention Agents that is supported by peer-reviewed literature or national treatment guidelines
- ☐ For a gepant, if using a different gepant:
  - ☐ Will discontinue use of the gepant prior to starting the requested gepant
  - ☐ Has a medical reason for concomitant use of both gebants that is supported by peer-reviewed literature or national treatment guidelines
- ☐ For Nurtec ODT for the prevention of migraine, has a documented history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for the member's indication
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

MIGRAINE PREVENTION:

- ☐ Member has a diagnosis of migraine with or without aura confirmed according to the current International Headache Society Classification of Headache Disorder
- ☐ Average number of migraine and headache days per month at baseline _____
- ☐ Member has 4 or more migraine days per month over the past 3 months
- ☐ Documented history of therapeutic failure, contraindication or intolerance that prohibits a trial of at least 1 from two of the following 3 classes: (medication, start date and end date)

- ☐ Beta-Blocker (e.g. metoprolol, propranolol, timolol):_____
- ☐ Antidepressant (e.g. amitriptyline, venlafaxine):_____
- ☐ Anticonvulsant (e.g. topiramate, valproic acid, divalproex):_____

MIGRAINE PREVENTION RENEWAL REQUESTS:

- ☐ Member has had a reduction in the average number of migraine and headache days per month from baseline _____
- ☐ Member has experienced a decrease in severity or duration of migraines from baseline evidenced by:_____

EPISODIC CLUSTER HEADACHE:

- ☐ Member has a diagnosis of episodic cluster headache confirmed according to the current International Headache Society Classification of Headache Disorder
- ☐ Documented history of therapeutic failure, contraindication or intolerance to at least 1 preventative medication recommended by consensus guidelines for episodic cluster headache (American Academy of Neurology, American Academy of Family Physicians, American Headache Society): (medication, start date and end date)
  - ☐ Verapamil:_____
  - ☐ Topiramate:_____

EPISODIC CLUSTER HEADACHE RENEWAL REQUESTS:

- ☐ Member has experienced a positive clinical response as evident by a reduction in cluster headache frequency from baseline_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider 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.)