



## 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 DOCUMENTATION <i>(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)</i>			
Specify diagnosis & diagnosis code relevant to this request:		Dx/Dx Code: _____	
Does the member have a history of contraindication to the prescribed medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Requests for all non-preferred medications:</b> Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Migraine Prevention Agents? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes      Medications Previously Taken (start and end date and dose): _____ <input type="checkbox"/> No        _____	
<input type="checkbox"/> 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: _____			
<input type="checkbox"/> Will discontinue use of Migraine Prevention Agent prior to starting the requested Migraine Prevention Agent <b>OR</b>			
<input type="checkbox"/> Has a medical reason for concomitant use of both Migraine Prevention Agents that is supported by peer-reviewed literature or national treatment guidelines			
<input type="checkbox"/> For a gepant, if using a different gepant:			
<input type="checkbox"/> Will discontinue use of the gepant prior to starting the requested gepant			
<input type="checkbox"/> Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines			
<input type="checkbox"/> For a preferred gepant 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 (medication, start and end date): _____			
<input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to <a href="https://www.pahealthwellness.com/providers/pharmacy.html">https://www.pahealthwellness.com/providers/pharmacy.html</a> under PHW Quantity Limit List), please provide supporting information: _____			
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.			
MIGRAINE PREVENTION:			
<input type="checkbox"/> Member has a diagnosis of migraine with or without aura confirmed according to the current International Headache Society Classification of Headache Disorder			
<input type="checkbox"/> Average number of migraine and headache days per month at baseline _____			
<input type="checkbox"/> Member has 4 or more migraine days per month over the past 3 months			
<input type="checkbox"/> 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:
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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.)