Prior Authorization Request Form for Migraine Acute Treatment 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 Acute Treatment 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):_____ _____ _____

☐ Member has a diagnosis confirmed according to the current International Headache Society Classification of Headache Disorder

THERAPEUTIC DUPLICATION:

☐ Is being titrated to or tapered from another drug in the same class
☐ Has medical reason for concomitant use of the requested medication is supported by national treatment guidelines or peer-review literature

EXCEEDS QUANTITY LIMITS:

☐ 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:_____
☐ Prescribed by a neurologist or headache specialist (certified in headache medicine but the United Council for Neurological Subspecialties (UCNS)), please indicate a specialist:_____
☐ For the acute treatment of migraine, both of the following:
  ☐ One of the following:
    ☐ Does the member have a history of therapeutic failure, contraindication or intolerance to one or more preventative medications from one of the following 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):_____
      ☐ CGRP Monoclonal Antibody (e.g. Aimovig, Emgality):_____
    ☐ Does the member have a history of therapeutic failure, contraindication or intolerance to standard first-line abortive medications based on headache classification as recommended by current consensus guidelines

(such as guidelines from American Academy of Neurology, American Academy of Family Physicians, American Headache Society) (medication, start date and end date):_____
_____

☐ Has documentation of an evaluation for the overuse of abortive medications, including opioids

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

REQUEST FOR GEPANT (NURTEC ODT, UBRELVY) FOR ACUTE TREATMENT OF MIGRAINE:

☐ Documented history of therapeutic failure, contraindication or intolerance to at least 2 5-HT $_{1B/1D}$ receptor agonists (triptans): (medication, start date and end date):_____
_____

☐ If currently using a different gepant, one of the following:
- ☐ Will discontinue use of the other gepant prior to starting the requested gepant
- ☐ Has medical reason for concomitant use of both gepants supported by peer-reviewed literature or national treatment guidelines

REQUEST FOR DITANS (REYVOW):

☐ Documented history of therapeutic failure, contraindication or intolerance to the preferred triptans (medication, start date and end date):_____
_____

REQUEST FOR ERGOT ALKALOIDS (DIHYDROERGOTAMINE):

☐ Documented history of therapeutic failure, contraindication or intolerance to standard first-line abortive medications based on headache classification as recommended by current consensus guidelines (such as guidelines from American Academy of Neurology, American Academy of Family Physicians, American Headache Society) (medication, start date and end date):_____
_____

REQUEST FOR NON-PREFERRED MIGRAINE ACUTE TREATMENT:

☐ For triptan:
- ☐ Documented history of therapeutic failure, contraindication or intolerance to preferred triptans (medication, start date and end date):_____
_____

☐ For all other non-preferred Migraine Acute Treatment:
- ☐ Documented history of therapeutic failure, contraindication or intolerance to preferred Migraine Acute Treatment approved or medically accepted for the member's diagnosis(medication, start date and end date):_____
_____

RENEWAL REQUESTS:

☐ Member has experienced an improvement in headache pain, symptoms or duration_____
_____

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.)