



# 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.covermyeds.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 (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?		<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 Acute Treatment 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 <input type="checkbox"/> No	
		Medications Previously Taken (start and end date and dose): _____ _____	
<input type="checkbox"/> Member has a diagnosis confirmed according to the current International Headache Society Classification of Headache Disorder			
THERAPEUTIC DUPLICATION:			
<input type="checkbox"/> Is being titrated to or tapered from another drug in the same class			
<input type="checkbox"/> Has medical reason for concomitant use of the requested medication is supported by national treatment guidelines or peer-review literature			
EXCEEDS QUANTITY LIMITS:			
<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: _____			
<input type="checkbox"/> Prescribed by a neurologist or headache specialist (certified in headache medicine but the United Council for Neurological Subspecialties (UCNS)), please indicate a specialist: _____			
<input type="checkbox"/> For the acute treatment of migraine, both of the following:			
<input type="checkbox"/> One of the following:			
<input type="checkbox"/> 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):			
<input type="checkbox"/> Beta-Blocker (e.g. metoprolol, propranolol, timolol): _____			
<input type="checkbox"/> Antidepressant (e.g. amitriptyline, venlafaxine): _____			
<input type="checkbox"/> Anticonvulsant (e.g. topiramate, valproic acid, divalproex): _____			
<input type="checkbox"/> CGRP Monoclonal Antibody (e.g. Aimovig, Emgality): _____			
<input type="checkbox"/> 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<sub>1B/1D</sub> 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.)