MIGRAINE ACUTE TREATMENT AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

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

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

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 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.

☐**For a NON-PREFERRED MIGRAINE ACUTE TREATMENT AGENT**

☐**For a non-preferred TRIPTAN:**

☐Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.):*_____

☐**For a non-preferred GEPANT:**

☐Tried and failed or has a contraindication or an intolerance to the preferred GEPANTS (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred gepants in the Migraine Acute Treatment Agents class.):*_____

☐**For ALL OTHER non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, etc.):**

☐Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class that are approved or medically accepted for the treatment of the member's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and*

*non-preferred drugs in the Migraine Acute Treatment Agents class.):*_____

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

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

☐ **For a DITAN/5HT1 RECEPTOR AGONIST (e.g., Reyvow)**

☐ Tried and failed or has a contraindication or intolerance to the preferred triptans (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class):*_____

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

☐ Tried and failed or has a contraindication or intolerance to the following:

☐ caffeine/analgesic combination (e.g., Excedrin)

☐ NSAIDs:_____

☐ triptans:_____

☐ a combination of an NSAID with a triptan:_____

☐ other: _____

RENEWAL requests

Check all of the following that apply to the member and this request and SUBMIT DOCUMENTATION for each item.

☐ Experienced improvement in headache pain, symptoms, or duration

☐ **For a NON-PREFERRED MIGRAINE ACUTE TREATMENT AGENT**

☐ **For a non-preferred TRIPTAN:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.):*_____

☐ **For a non-preferred GEPANT:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred GEPANTS (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred gepants in the Migraine Acute Treatment Agents class.):*_____

☐ **For ALL OTHER non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, etc.):**

☐ Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class that are approved or medically accepted for the treatment of the member's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in the Migraine Acute Treatment Agents class.):*_____

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 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.*

pa health & wellness™

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)
- ☐ beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐ botulinum toxin (e.g., Botox, Dysport)
- ☐ CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
- ☐ gepant (e.g., Nurtec ODT, Qulipta)
- ☐ other: _____

☐ Tried and failed preventive migraine medications – specify:

- ☐ anticonvulsant (e.g., topiramate, valproate derivative)
- ☐ antidepressant (e.g., SNRI, TCA)
- ☐ beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐ botulinum toxin (e.g., Botox, Dysport)
- ☐ CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
- ☐ gepant (e.g., Nurtec ODT, Qulipta)
- ☐ other: _____

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

- ☐ anticonvulsant (e.g., topiramate, valproate derivative)
- ☐ antidepressant (e.g., SNRI, TCA)
- ☐ beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐ botulinum toxin (e.g., Botox, Dysport)
- ☐ CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
- ☐ gepant (e.g., Nurtec ODT, Qulipta)
- ☐ other: _____

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.)