MIGRAINE PREVENTION 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 Prevention 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	# 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

Drug requested:	Strength:	Formulation (pen, syringe, tablet, etc):	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Is the drug prescribed by or in consultation with a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties or a neurologist?		☐Yes ☐No *Submit documentation of consultation, if applicable.*	

Complete all sections that apply to the member and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. **For PREVENTION OF MIGRAINE:**
   - ☐Averaged 4 or more migraine days per month over the past 3 months
   - ☐Tried and failed (or cannot try) at least 1 other preventive migraine drug from 1 of the following 3 classes:
     - ☐Anticonvulsants (e.g., divalproex, topiramate, valproic acid):______________________
     - ☐Antidepressants (e.g., amitriptyline, venlafaxine):______________________
     - ☐Beta blockers (e.g., metoprolol, propranolol, timolol):______________________
2. **For EPISODIC CLUSTER HEADACHE:**
   - ☐Tried and failed (or cannot try) at least one other preventive medication:______________________
3. **For a GEPANT (e.g., Nurtec ODT, Qulipta) for PREVENTION OF MIGRAINE:**
   - ☐Tried and failed (or cannot try) at least 2 preferred CGRP monoclonal antibodies approved or medically accepted for the diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention*

pa health & wellness

*Agents.):*__________

☐ **For a NON-PREFERRED gepant for prevention of migraine:**

☐ Tried and failed (or cannot try) the preferred gepants approved or medically accepted for the indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred gepants.):*__________

4. **For all other NON-PREFERRED Migraine Prevention Agents (except gepants):**

☐ Tried and failed or has a contraindication or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents.):*__________

RENEWAL requests

1. **For PREVENTION OF MIGRAINE:**

☐ Experienced fewer average migraine days or headache days per month since starting the requested medication

☐ Experienced a decrease in severity or duration of migraines since starting the requested medication

2. **For EPISODIC CLUSTER HEADACHE:**

☐ Experienced a reduction in the frequency of episodic cluster headache since starting the requested medication

3. **For a GEPANT (e.g., Nurtec ODT, Qulipta) for PREVENTION OF MIGRAINE:**

☐ Tried and failed (or cannot try) at least 2 preferred CGRP monoclonal antibodies approved or medically accepted for the indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents.):*__________

☐ **For a NON-PREFERRED gepant for prevention of migraine:**

☐ Tried and failed (or cannot try) the preferred gepants approved or medically accepted for the diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred gepants.):*__________

4. **For all other NON-PREFERRED Migraine Prevention Agents (except gepants):**

☐ Tried and failed or has a contraindication or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents.):*__________

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber 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.)