pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

MIGRAINE ACUTE TREATMENT AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/3/2022)*

Prior authorization guidelines for **Migraine Acute Treatment Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐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:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary 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 DHS website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx for applicable limits.

INITIAL requests

Check all of the following that apply to the beneficiary 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 ALL OTHER non-preferred Migraine Acute Treatment Agents:
  - ☐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 beneficiary'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	
Has the beneficiary experienced an improvement in headache pain, symptoms, and/ or duration since starting the requested medication?	☐Yes ☐No *Submit documentation.*

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 DHS website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx 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.*

For ACUTE TREATMENT OF MIGRAINE, check all that apply to the beneficiary 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)
- ☐beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐antidepressant (e.g., SNRI, TCA)
- ☐CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
- ☐other: ______________________________

☐Tried and failed preventive migraine medications – specify:
- ☐anticonvulsant (e.g., topiramate, valproate derivative)
- ☐beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐antidepressant (e.g., SNRI, TCA)
- ☐CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
- ☐other: ______________________________

☐Has an intolerance or a contraindication to preventive migraine medications – specify:
- ☐anticonvulsant (e.g., topiramate, valproate derivative)
- ☐beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐antidepressant (e.g., SNRI, TCA)
- ☐CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
- ☐other: ______________________________

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.