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 PREVENTION AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Migraine Prevention 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 | # 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

| | | | |
|---|---|---|---|
| Drug requested: | Strength: | Formulation (pen, syringe, tablet, etc): | |
| Dose/directions: | | Quantity: | Refills: |
| Diagnosis *(submit documentation)*: | | Dx code (*required*): | |
| Is the medication being 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.* |

### INITIAL requests

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

☐For PREVENTION OF MIGRAINE:
- ☐Averaged 4 or more migraine days per month over the past 3 months
- ☐Tried and failed (or cannot try) other preventive migraine medications
  - ☐Anticonvulsants (e.g., divalproex, topiramate, valproic acid)
  - ☐Antidepressants (e.g., amitriptyline, venlafaxine)
  - ☐Beta blockers (e.g., metoprolol, propranolol, timolol)

☐For EPISODIC CLUSTER HEADACHE:
- ☐Tried and failed (or cannot try) at least one other preventive medication

☐For NURTEC ODT (rimegepant) for PREVENTION OF MIGRAINE:
- ☐Tried and failed (or cannot try) the 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 Agents)*

☐For a NON-PREFERRED Migraine Prevention Agent:
- ☐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

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

☐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

☐For EPISODIC CLUSTER HEADACHE:
- ☐Experienced a reduction in the frequency of episodic cluster headache since starting the requested medication

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

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|---|---|
| Prescriber Signature: | Date: |