

ANTIMIGRAINE AGENTS, OTHER PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Antimigraine Agents, Other, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antimigraine Agents, Other** and **Quantity Limits/Daily Dose Limits** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:	<input type="checkbox"/> Cafergot tablet	<input type="checkbox"/> dihydroergotamine (DHE) injection ampule
	<input type="checkbox"/> Cambia powder packet	<input type="checkbox"/> Migranal nasal spray
	<input type="checkbox"/> dihydroergotamine (DHE) nasal spray	<input type="checkbox"/> Nodolor capsule
Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	DX code (<i>required</i>):	

INITIAL REQUESTS

1. Does the Recipient have a diagnosis of migraine headache that is consistent with current International Classification of Headache Disorders (ICHD) criteria?	<input type="checkbox"/> Yes	<i>Submit documentation of diagnosis.</i>
	<input type="checkbox"/> No	
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance to all of the following? <i>Check all that apply.</i> <input type="checkbox"/> NSAIDs <input type="checkbox"/> triptans <input type="checkbox"/> a combination of an NSAID with a triptan	<input type="checkbox"/> Yes	<i>Submit documentation.</i>
	<input type="checkbox"/> No	
3. Does the Recipient have any of the following contraindications to the requested medication, including but not limited to the following? <i>Check all that apply.</i> <input type="checkbox"/> currently pregnant or breastfeeding <input type="checkbox"/> heart disease (such as peripheral vascular disease, coronary artery disease, ischemic heart disease, and history of MI) <input type="checkbox"/> hypertension <input type="checkbox"/> cerebrovascular insufficiency <input type="checkbox"/> liver impairment <input type="checkbox"/> kidney impairment <input type="checkbox"/> glaucoma	<input type="checkbox"/> Yes	<i>Submit documentation.</i>
	<input type="checkbox"/> No	
4. Is the Recipient currently taking any medications that are contraindicated with the requested medication (ex, ergot derivatives, strong CYP3A4 inhibitors, peripheral or central vasoconstrictors, MAO inhibitors)?	<input type="checkbox"/> Yes	<i>Submit Recipient's complete current medication list.</i>
	<input type="checkbox"/> No	

RENEWAL REQUESTS

1. Has the Recipient experienced an improvement in migraine control since starting the requested medication?	<input type="checkbox"/> Yes	<i>Submit documentation.</i>
	<input type="checkbox"/> No	
2. Does the Recipient have any contraindications to the requested agent?	<input type="checkbox"/> Yes	<i>Submit documentation.</i>
	<input type="checkbox"/> No	
3. Is the Recipient currently taking any medications that are contraindicated with the requested medication (ex, ergot derivatives, strong CYP3A4 inhibitors, peripheral or central vasoconstrictors, MAO inhibitors)?	<input type="checkbox"/> Yes	<i>Submit Recipient's complete current medication list.</i>
	<input type="checkbox"/> No	

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.