MIGRAINE ACUTE TREATMENT AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/6/2025)

Keystone First Community HealthChoices | PerformRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:	Phone:	

PRESCRIBER INFORMATION

Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	

CLINICAL INFORMATION

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

Preferred:		Non-Preferred:	
☐ Eletriptan Tablet	☐ Sumatriptan Pen Injector	☐ Almotriptan Tablet	☐ Migranal Nasal Spray
☐ Naratriptan Tablet	☐ Sumatriptan Tablet	☐ Diclofenac Potassium Powder Packet	☐ Relpax Tablet
☐ Nurtec (rimegepant) ODT	☐ Sumatriptan Vial	☐ Dihydroergotamine Mesylate Ampule	☐ Reyvow Tablet
☐ Rizatriptan ODT	☐ Ubrelvy Tablet	☐ Dihydroergotamine Mesylate Nasal Spray	☐ Sumatriptan-Naproxen Tablet
☐ Rizatriptan Tablet	☐ Zolmitriptan ODT	☐ Elyxyb Solution	☐ Tosymra Nasal Spray
☐ Sumatriptan Cartridge	☐ Zolmitriptan Tablet	☐ Frova Tablet	☐ Trudhesa Nasal Spray
☐ Sumatriptan Nasal Spray		☐ Frovatriptan Tablet	☐ Zavzpret Nasal Spray
		☐ Imitrex Cartridge	☐ Zembrace Symtouch
		☐ Imitrex Pen Injector	☐ Zolmitriptan Nasal Spray
		☐ Imitrex Tablet	☐ Zomig Nasal Spray
		☐ Maxalt Tablet	☐ Zomig Tablet
		☐ Maxalt MLT	

Strength and dosage form:		
Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code *(required)*:

INITIAL REQUESTS

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.

1. 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.)
- ☐ List medications tried: _____

☐ **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.)
- ☐ List medications tried: _____

☐ **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 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.)
- ☐ List medications tried: _____

☐ **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

INITIAL REQUESTS

☐ **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)
- ☐ List medications tried: _____

☐ **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 beneficiary 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.)
  - ☐ List medications tried: _____
- ☐ **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.)
  - ☐ List medications tried: _____
- ☐ **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 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.)
  - ☐ List medications tried: _____

QUANTITY LIMITS/DAILY DOSE LIMITS REQUESTS

All requests that exceed the quantity limits/daily dose limits require prior authorization.

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.

1. <u>For ACUTE TREATMENT OF MIGRAINE, check all that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each:</u>

☐ 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

Prescriber signature:	Date: