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

ANTIMIGRAINE AGENTS, TRIPTANS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antimigraine Agents, Triptans** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

- ☐almotriptan tablet
- ☐Amerge tablet
- ☐Axert tablet
- ☐eletriptan tablet
- ☐Frova tablet
- ☐frovatriptan tablet
- ☐Imitrex nasal spray
- ☐Imitrex SQ injection cartridge
- ☐Imitrex SQ injection pen
- ☐Imitrex SQ injection vial
- ☐Imitrex tablet
- ☐Maxalt MLT
- ☐Maxalt tablet
- ☐naratriptan tablet
- ☐Onzetra Xsail nasal powder
- ☐Relpax tablet
- ☐sumatriptan/naproxen tablet
- ☐Sumavel DosePro SQ injection
- ☐Treximet tablet
- ☐Zembrace Symtouch pen injector
- ☐zolmitriptan tablet
- ☐zolmitriptan ODT
- ☐Zomig tablet
- ☐Zomig ZMT
- ☐_____

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

ALL non-preferred requests

1. Has the beneficiary tried and failed any of the following preferred Antimigraine Agents, Triptans? *Check all that apply.* ☐rizatriptan tablet ☐rizatriptan ODT ☐sumatriptan tablet ☐sumatriptan nasal spray ☐sumatriptan SQ pen injector & cartridge ☐sumatriptan SQ vial ☐Zomig nasal spray	☐Yes – *Submit all supporting documentation of drug regimens tried and treatment outcomes.* ☐No
2. Does the beneficiary have any contraindications or intolerances to the preferred Antimigraine Agents, Triptans listed in question (1)?	☐Yes – *Submit all supporting documentation of medication names and associated intolerances and contraindications.* ☐No

ALL requests that exceed the quantity limit/daily dose limit

1. Does the beneficiary have an evaluation showing a diagnosis of chronic, severe migraine as per the International Classification of Headache Disorders (ICHD) criteria?	☐Yes – *Submit documentation of evaluation.* ☐No
2. Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the following medication classes used for migraine prevention? *Check all that apply.* ☐anticonvulsants ☐calcium channel blockers ☐TCAs ☐beta blockers ☐NSAIDs ☐SSRIs	☐Yes – *Submit all supporting documentation of medication names and associated intolerances and contraindications.* ☐No

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

Prescriber Signature:	**Date**: