

## ANTIMIGRAINE AGENTS, OTHER – ACUTE TREATMENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antimigraine Agents, Other** 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>.

<input type="checkbox"/> New request <input type="checkbox"/> 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

<b>Drug requested:</b>		Strength & dosage form:												
To request a CGRP inhibitor (e.g., Aimovig, Ajovy, Emgality, etc), please use the Antimigraine, Other – CGRP Inhibitors form.														
Dose/directions:		Quantity:	Refills:											
Diagnosis ( <i>submit documentation</i> ):		DX code ( <i>required</i> ):												
<p>Does the beneficiary have any of the following contraindications to the requested medication, including but not limited to the following? <i>Check all that apply.</i></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> currently pregnant or breastfeeding</td> <td><input type="checkbox"/> heart disease (such as peripheral vascular disease, coronary artery disease, ischemic heart disease, and history of MI)</td> <td rowspan="5" style="vertical-align: middle; padding-left: 20px;"> <input type="checkbox"/> Yes  <input type="checkbox"/> No    <i>Submit documentation.</i> </td> </tr> <tr> <td><input type="checkbox"/> hypertension</td> <td><input type="checkbox"/> cerebrovascular insufficiency</td> </tr> <tr> <td><input type="checkbox"/> liver impairment</td> <td></td> </tr> <tr> <td><input type="checkbox"/> kidney impairment</td> <td></td> </tr> <tr> <td><input type="checkbox"/> sepsis</td> <td></td> </tr> </table>		<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"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>	<input type="checkbox"/> hypertension	<input type="checkbox"/> cerebrovascular insufficiency	<input type="checkbox"/> liver impairment		<input type="checkbox"/> kidney impairment		<input type="checkbox"/> sepsis			
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<input type="checkbox"/> kidney impairment														
<input type="checkbox"/> sepsis														
Is the beneficiary currently taking any medications that are contraindicated with the requested medication (e.g., strong CYP3A4 inhibitors [e.g., protease inhibitors, azole antifungals, some macrolide antibiotics], peripheral or central vasoconstrictors, MAO inhibitors)?		<input type="checkbox"/> Yes <i>Submit beneficiary's complete current medication list.</i> <input type="checkbox"/> No												
<b>INITIAL Requests</b>														
Does the beneficiary have a diagnosis of 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												
<p>Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? <i>Check all that apply.</i></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> caffeine/analgesic combination (e.g., Excedrin)</td> <td><input type="checkbox"/> triptans</td> <td rowspan="2" style="vertical-align: middle; padding-left: 20px;"> <input type="checkbox"/> Yes  <input type="checkbox"/> No    <i>Submit documentation.</i> </td> </tr> <tr> <td><input type="checkbox"/> NSAIDs</td> <td><input type="checkbox"/> a combination of an NSAID with a triptan</td> </tr> </table>		<input type="checkbox"/> caffeine/analgesic combination (e.g., Excedrin)	<input type="checkbox"/> triptans	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>	<input type="checkbox"/> NSAIDs	<input type="checkbox"/> a combination of an NSAID with a triptan								
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<b>RENEWAL Requests</b>														
Has the beneficiary experienced an improvement in headache pain control or duration since starting the requested medication?		<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No												

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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