

ANTIMIGRAINE AGENTS, OTHER – CGRP INHIBITORS 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	# 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, etc):	
Dose/directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		DX code (<i>required</i>):	
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?		<input type="checkbox"/> Yes <i>Submit documentation of</i> <input type="checkbox"/> No <i>consultation, if applicable.</i>	

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 therapies
 - Beta blockers (e.g., metoprolol, propranolol, timolol)
 - Antidepressants (e.g., amitriptyline, venlafaxine)
 - Anticonvulsants (e.g., divalproex, topiramate, valproic acid)
- For EPISODIC CLUSTER HEADACHE:**
 - Tried and failed (or cannot try) at least one other preventive medication
- For a NON-PREFERRED CGRP inhibitor:**
 - Tried and failed or has a contraindication or intolerance to the preferred CGRP inhibitor(s) approved or medically accepted for the diagnosis (refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred CGRP inhibitors)

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 a decreased number of 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 decrease in the frequency of episodic cluster headache since starting the requested medication

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

Prescriber Signature:	Date:
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