MOLINA HEALTHCARE

Iowa Health Link IOWA HHS Hawki Iowa HHS (P□□A□□ PR□□ – A□□□RA□□ □□ □MP□R□A□□)

Request for Prior Authorization

Select Preventative Migraine Treatments

FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464

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Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

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Prior authorization is required for select preventative migraine treatments. Payment for non-preferred select preventative migraine agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred select preventative migraine agent. Payment will be considered under the following conditions:

1. **Patient has one of the following diagnoses:**
   a. **Chronic Migraine, defined as:**
      i. **≥ 15 headache days per month for a minimum of 3 months; and**
      ii. **≥ 8 migraine headache days per month for a minimum of 3 months; or**
   b. **Episodic Migraine, defined as:**
      i. **4 to 14 migraine days per month for a minimum of 3 months; or**
   c. **Episodic Cluster Headache, defined as:**
      i. **Occurring with a frequency between one attack every other day and 8 attacks per day; and**
      ii. **With at least 2 cluster periods lasting 7 days to one year (when untreated) and separated by pain-free remission periods of ≥ 3 months; and**
      iii. **Patient does not have chronic cluster headache (attacks occurring without a remission period, or with remissions lasting < 3 months, for at least 1 year); and**
2. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions and use in specific populations; and**
3. **The requested agent will not be used in combination with another CGRP inhibitor for the preventative treatment of migraine; and**
4. **Patient has been evaluated for and does not have medication overuse headache; and**
5. **For Episodic and Chronic Migraine, patient has documentation of two trials and therapy failures, of at least three months per agent, at a maximally tolerated dose with two different migraine prophylaxis drug classes (i.e., anticonvulsants [divalproex, valproate, topiramate], beta blockers [atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [amitriptyline, venlafaxine]; or**
6. **For Episodic Cluster Headache, patient has documentation of:**
   a. **A previous trial and therapy failure at an adequate dose with glucocorticoids (prednisone 30mg per day or dexamethasone 8mg BID) started promptly at the start of a cluster period. Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamine, lidocaine) at least once daily for at least two days per week after the first full week of adequately dosed steroid therapy; and**

b. A previous trial and therapy failure at an adequate dose of verapamil for at least 3 weeks (total daily dose of 480mg to 960mg). Failure is defined as the need to use acute/abortive medications (oxygen, triptans, ergotamines, lidocaine) at least once daily for at least two days per week after three weeks of adequately dosed verapamil therapy.

7. Lost, stolen, or destroyed medication replacement requests will not be authorized.

Initial requests will be approved for three months. Additional prior authorizations will be considered upon documentation of clinical response to therapy (i.e., reduced migraine frequency, reduced migraine headache days, reduced weekly cluster headache attack frequency).

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred **Non-Preferred**

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Strength	Dosage Instructions	Quantity	Days Supply
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Diagnosis:

☐ **Chronic Migraine (must document each criterion below):**

1□ Patient has ≥ 15 headache days per month for a minimum of 3 months
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2□ Patient has ≥ 8 migraine headache days per month for a minimum of 3 months
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☐ **Episodic Migraine:**

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Chronic or Episodic Migraine treatment failures:

Trial 1: □□□ □□D□□□□_____ □r□□□D□□□□□_____

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Trial 2: □□□ □□D□□□□_____ □r□□□D□□□□□_____

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☐ **Episodic Cluster Headache (must document each criterion below):**

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Episodic Cluster Headache treatment failures:

Glucocorticoid Trial: □□□ □□D□□□□ _____ □r□□□D□□□□ _____

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Verapamil Trial: □□□ □□D□□□□ _____ □r□□□D□□□□ _____

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Has patient been evaluated and medication overuse headache ruled out? ☐ □□□ ☐ □□

Is requested agent being used in combination with another CGRP inhibitor for the preventative treatment of migraine? ☐ □□□ ☐ □□

☐ **Requests for Non-Preferred Agents:** D□□□□ □□□□r□□□□□ □□□□□r□□□□□□□ □ □r□□□ □□□□

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☐ **Renewal Requests:** D□□□□ □□□□□□□□r□□□□□ □□ □□r□□□ _____

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Attach lab results and other documentation as necessary.

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IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*