

Request for Prior Authorization



ACUTE MIGRAINE TREATMENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

IA Medicaid Member ID #	P	atient name			DOB		
Patient address							
Provider NPI Prescriber		Prescriber nai	ame		Phone		
Prescriber address					Fax		
	<u> </u>						
Pharmacy name Address					Phone		
Prescriber must complet	e all information	on above. It mu	st be legible, correct,	and complete or fo	orm will be r	eturned.	
Pharmacy NPI Pha		Pharmacy fax	Pharmacy fax				
No prior authorization (Pa	• • • • • • • • • • • • • • • • • • • •						
PDL, documentation of pr preferred acute migraine require PA. Requests for r preferred CGRP inhibitor; current prophylactic thera and/or 6) For non-preferre ingredients, in addition to trials may be overridden v	treatments, doo non-preferred C ; and/or 5) For apy or documer ed combination the above crite	cumentation of CGRP inhibitors quantities exced ntation of previo products, docu eria for preferre	previous trials and the will also require docu eding the established ous trials and therapy mentation of separated d or non-preferred ac	erapy failures with imentation of a tria quantity limit for e failures with two d e trials and therapy ute migraine treat	two preferre al and therap ach agent, d ifferent prop failures with ments requi	ed agents that do not y failure with a ocumentation of hylactic medications n the individual ring PA. The require	
Preferred 5-HTI- Receptor		·	Non- Preferred 5-H	_			
(PA required after 12 dose			(PA required from D	•			
☐ Imitrex NS	☐ Zolmit	riptan Tabs	☐ Almotriptan	☐ Maxalt		☐ Tosymra	
□ Naratriptan			☐ Amerge	☐ Maxalt MLT		☐ Treximet	
Rizatriptan ODT			☐ Eletriptan	Onzetra Xsail		☐ Zembrace	
Rizatriptan Tablets			☐ Frova	☐ Relpax		☐ Zolmitriptan NS	
Sumatriptan Inj			Frovatriptan	Reyvow		Zomig NS	
Sumatriptan NS Sumatriptan Tablets			☐ Imitrex Inj/Tabs	Sumansetron Sumatriptan-N	aproxen	☐ Zomig Tabs☐ Zomig ZMT	
Preferred CGRP Inhbitors	•		Non-Preferred CGR		•	_ 0	
(PA required)			(PA required)				
☐ Nurtec (Quantity limit I	5 doses per 30 da	ays)	Ubrelvy				
Strength Dosage Inst			uctions	Qua	ntity	Days Supply	
Diagnosis:							
Please document the cu prophylactic medication	ırrent prophy	lactic therapy	or 2 previous trials	and therapy failu		o different	
For Preferred Agents R	equiring PA:	document tria	ls with two preferre	ed agents that do	not require	e PA	
Preferred Trial I: Name/Do	ose:			Trial Dates:			
Failure reason:							
Preferred Trial 2: Name/Do							
Failure reason:							

Request for Prior Authorization

ACUTE MIGRAINE TREATMENTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

For Non-Preferred Agents Requiring PA: document trials with two preferred agents that do not require PA and a preferred GGRP inhibitor trial, if applicable

Preferred Trial 1: Name/Dose:	Trial Dates:		
Failure reason:			
Preferred Trial 2: Name/Dose:	Trial Dates:		
Failure reason:			
Preferred CGRP Inhibitor Trial: Name/Dose:	Trial Dates:		
Failure reason:			
For quantities exceeding the established quantity limit: therapy failures with two different prophylactic medical	document current prophylactic therapy or previous trials and ions		
Preferred Prophylactic Trial 1: Name/Dose:	Trial Dates:		
Failure reason:			
Preferred Prophylactic Trial 2: Name/Dose:	Trial Dates:		
Failure reason:			
For Non-Preferred Combination Products: document to addition to above criteria for preferred or non-preferre	rials and therapy failures with the individual ingredients (in d treatments requiring PA)		
Trial I: Name/Dose:	Trial Dates:		
Failure reason:			
Trial 2: Name/Dose:	Trial Dates:		
Failure reason:			
Medical or contraindication reason to override trial requiremen	ts:		
Reason for use of Non-Preferred drug requiring prior approval:			
Other medical conditions to consider:			
Attach lab results and other documentation as necessary.			
Prescriber signature (Must match prescriber listed above.)	Date of submission		

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 Human Services, that the member continues to be eligible for Medicaid.

PAA-1002 Page 2 of 2