HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

MIGRAINE PREVENTION AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

Prior authorization guidelines for **Migraine Prevention Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html.

☐New request ☐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:		City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Formulation (pen, syringe, tablet, etc):	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Is the drug 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?		☐Yes ☐No	*Submit documentation of consultation, if applicable.*

Complete all sections that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. **For PREVENTION OF MIGRAINE:**
   - ☐Averaged 4 or more migraine days per month over the past 3 months
   - ☐Tried and failed (or cannot try) at least 1 other preventive migraine drug from 1 of the following 3 classes:
     - ☐Anticonvulsants (e.g., divalproex, topiramate, valproic acid)
     - ☐Antidepressants (e.g., amitriptyline, venlafaxine)
     - ☐Beta blockers (e.g., metoprolol, propranolol, timolol)
2. **For EPISODIC CLUSTER HEADACHE:**
   - ☐Tried and failed (or cannot try) at least one other preventive medication
3. **For a GEPANT (e.g., Nurtec ODT, Qulipta) for PREVENTION OF MIGRAINE:**
   - ☐Tried and failed (or cannot try) at least 2 preferred CGRP monoclonal antibodies approved or medically accepted for the diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents.)*
   - ☐**For a NON-PREFERRED gepant for prevention of migraine:**
     - ☐Tried and failed (or cannot try) the preferred gepants approved or medically accepted for the indication (*Refer to*

https://papdl.com/preferred-drug-list for a list of preferred and non-preferred gepants.)

4. **For all other NON-PREFERRED Migraine Prevention Agents (except gepants):**
   ☐ Tried and failed or has a contraindication or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents.)*

RENEWAL requests

1. **For PREVENTION OF MIGRAINE:**
   ☐ Experienced fewer average 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
2. **For EPISODIC CLUSTER HEADACHE:**
   ☐ Experienced a reduction in the frequency of episodic cluster headache since starting the requested medication
3. **For a GEPANT (e.g., Nurtec ODT, Qulipta) for PREVENTION OF MIGRAINE:**
   ☐ Tried and failed (or cannot try) at least 2 preferred CGRP monoclonal antibodies approved or medically accepted for the indication (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents.)*

   ☐ **For a NON-PREFERRED gepant for prevention of migraine:**
      ☐ Tried and failed (or cannot try) the preferred gepants approved or medically accepted for the diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred gepants.)*
4. **For all other NON-PREFERRED Migraine Prevention Agents (except gepants):**
   ☐ Tried and failed or has a contraindication or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents.)*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: