pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIMIGRAINE AGENTS, TRIPTANS PRIOR AUTHORIZATION FORM

Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
To review the prior authorization guidelines for Antimigraine Agents, Triptans, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Antimigraine Agents, Triptans** and **Quantity Limits/Daily Dose Limits** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

- ☐almotriptan tablet
- ☐Alsuma injection
- ☐Amerge tablet
- ☐Axert tablet
- ☐Frova tablet
- ☐frovatriptan tablet
- ☐Imitrex nasal spray
- ☐Imitrex tablet
- ☐Imitrex SQ injection cartridge
- ☐Imitrex SQ injection pen
- ☐Imitrex SQ injection vial
- ☐Maxalt MLT
- ☐Maxalt tablet
- ☐naratriptan tablet
- ☐Onzetra Xsail nasal powder
- ☐Relpax tablet
- ☐sumatriptan SQ injection syringe
- ☐Sumavel DosePro SQ injection
- ☐Treximet tablet
- ☐Zembrace Symtouch pen injector
- ☐zolmitriptan tablet
- ☐zolmitriptan ODT
- ☐Zomig nasal spray
- ☐Zomig tablet
- ☐Zomig ZMT
- ☐_____

Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

ALL non-preferred requests

1. Has the Recipient tried and failed any of the following preferred Antimigraine Agents, Triptans? *Check all that apply.* ☐rizatriptan tablet ☐sumatriptan nasal spray ☐rizatriptan ODT ☐sumatriptan SQ pen injector & cartridge ☐sumatriptan tablet ☐sumatriptan SQ vial	☐Yes – *Submit all supporting documentation of drug regimens tried and treatment outcomes.* ☐No
2. Does the Recipient have any contraindications or intolerances to the preferred Antimigraine Agents, Triptans listed in question (1)?	☐Yes – *Submit all supporting documentation of medication names and associated intolerances and contraindications.* ☐No

ALL requests that exceed the quantity limit/daily dose limit

1. Does the Recipient have an evaluation showing a diagnosis of chronic, severe migraine as per the International Classification of Headache Disorders (ICHD) criteria?	☐Yes – *Submit documentation of evaluation.* ☐No
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the following medication classes used for migraine prevention? *Check all that apply.* ☐anticonvulsants ☐calcium channel blockers ☐TCAs ☐beta blockers ☐NSAIDs ☐SSRIs	☐Yes – *Submit all supporting documentation of medication names and associated intolerances and contraindications.* ☐No

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

Prescriber Signature:	**Date**: