Pennsylvania
Department of Human Services

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

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

Prior authorization guidelines for **Migraine Acute Treatment 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	total # 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

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

Drug requested:	Strength & dosage form:	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Please complete either the INITIAL requests or RENEWAL requests section. If the requested prescription exceeds the quantity limits/daily dose limits, also complete the QUANTITY LIMITS/DAILY DOSE LIMITS section. Please refer to the DHS website at https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html for applicable limits.

INITIAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐For a NON-PREFERRED MIGRAINE ACUTE TREATMENT AGENT

- ☐For a non-preferred TRIPTAN:
  - ☐Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.)*
- ☐For a non-preferred GEPANT:
  - ☐Tried and failed or has a contraindication or an intolerance to the preferred GEPANTS (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred gepants in the Migraine Acute Treatment Agents class.)*
- ☐For ALL OTHER non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, etc.):
  - ☐Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class that are approved or medically accepted for the treatment of the beneficiary's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in the Migraine Acute Treatment Agents class.)*

☐For a GEPANT/SMALL MOLECULE CGRP INHIBITOR (e.g., Nurtec ODT, Ubrelvy)

- ☐Tried and failed at least 2 triptans (e.g., rizatriptan, sumatriptan, etc.) or has a contraindication or intolerance to triptans

☐ For a DITAN/5HT1 RECEPTOR AGONIST (e.g., Reyvow)
- ☐ Tried and failed or has a contraindication or intolerance to the preferred triptans (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class)*

☐ For an ERGOT ALKALOID (e.g., Cafergot, D.H.E., Migranal, etc.)
- ☐ Tried and failed or has a contraindication or intolerance to the following:
  - ☐ caffeine/analgesic combination (e.g., Excedrin)
  - ☐ NSAIDs
  - ☐ triptans
  - ☐ a combination of an NSAID with a triptan
  - ☐ other: _____

RENEWAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Experienced improvement in headache pain, symptoms, or duration

☐ For a NON-PREFERRED MIGRAINE ACUTE TREATMENT AGENT
- ☐ For a non-preferred TRIPTAN:
  - ☐ Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.)*
- ☐ For a non-preferred GEPANT:
  - ☐ Tried and failed or has a contraindication or an intolerance to the preferred GEPANTS (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred gepants in the Migraine Acute Treatment Agents class.)*
- ☐ For ALL OTHER non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, etc.):
  - ☐ Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class that are approved or medically accepted for the treatment of the beneficiary's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in the Migraine Acute Treatment Agents class.)*

QUANTITY LIMITS/DAILY DOSE LIMITS requests

All requests that exceed the quantity limits/daily dose limits established by DHS require prior authorization.
Please refer to the DHS website at https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html for applicable limits.

Is the requested medication prescribed by a neurologist or specialist certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)?	☐ Yes ☐ No
Is the requested quantity/dose/frequency supported by current medical compendia and/or peer-reviewed medical literature?	☐ Yes ☐ No *Submit documentation.*

For ACUTE TREATMENT OF MIGRAINE, check all that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each:

☐ Was evaluated for the overuse of abortive headache medications (e.g., opioids, triptans, butalbital, etc.)

☐ Will be using the requested medication with at least one medication for migraine prevention – specify:
- ☐ anticonvulsant (e.g., topiramate, valproate derivative)
- ☐ antidepressant (e.g., SNRI, TCA)
- ☐ beta blocker (e.g., metoprolol, propranolol, timolol)
- ☐ botulinum toxin (e.g., Botox, Dysport)
- ☐ CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
- ☐ gepant (e.g., Nurtec ODT, Qulipta)
- ☐ other: _____

☐ Tried and failed preventive migraine medications – specify:

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☐anticonvulsant (e.g., topiramate, valproate derivative)
☐antidepressant (e.g., SNRI, TCA)
☐beta blocker (e.g., metoprolol, propranolol, timolol)
☐botulinum toxin (e.g., Botox, Dysport)
☐CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
☐gepant (e.g., Nurtec ODT, Qulipta)
☐other: _____

☐Has an intolerance or a contraindication to preventive migraine medications – specify:

☐anticonvulsant (e.g., topiramate, valproate derivative)
☐antidepressant (e.g., SNRI, TCA)
☐beta blocker (e.g., metoprolol, propranolol, timolol)
☐botulinum toxin (e.g., Botox, Dysport)
☐CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
☐gepant (e.g., Nurtec ODT, Qulipta)
☐other: _____

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

Prescriber Signature:	Date: