



MIGRAINE ACUTE TREATMENT AGENTS PRIOR AUTHORIZATION FORM (form effective 1/5/2026)

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/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request <input type="checkbox"/> 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

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

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/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits> for applicable limits.

INITIAL requests

Check all of the following that apply to the beneficiary and this request and **SUBMIT DOCUMENTATION** for each item. Refer to <https://papdl.com/preferred-drug-list> for a list of preferred & non-preferred drugs in the Migraine Acute Treatment Agents class.

1. For a GEPANT / SMALL MOLECULE CGRP INHIBITOR for the acute treatment of migraine (e.g., Nurtec ODT, Ubrovelvy)

- Tried and failed at least 2 TRIPTANS (e.g., rizatriptan, sumatriptan, etc.) or has a contraindication or an intolerance to TRIPTANS
- For a NON-PREFERRED GEPANT:**
 - Tried and failed or has a contraindication or an intolerance to the preferred GEPANTS

2. For a DITAN / 5HT1 RECEPTOR AGONIST (e.g., Reyvow):

- Tried and failed or has a contraindication or intolerance to the preferred TRIPTANS
- For a NON-PREFERRED DITAN:**
 - Tried and failed or has a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents

3. For an ERGOT ALKALOID (e.g., Cafergot, D.H.E., Migranal, etc.)

- Tried and failed or has a contraindication or intolerance to the following abortive drugs:
 - caffeine/analgesic combination (e.g., Excedrin)
 - NSAIDs
 - triptans
 - a combination of an NSAID with a triptan
 - other: _____



For a NON-PREFERRED ERGOT ALKALOID:

Tried and failed or has a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents

4. For a NON-PREFERRED TRIPTAN:

Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS

5. For a NON-PREFERRED NSAID (e.g., Elyxyb, diclofenac powder packet):

Tried and failed or has a contraindication or an intolerance to the preferred oral NSAIDs in the NSAIDs PDL class

6. For a NON-PREFERRED TRIPTAN-NSAID COMBINATION PRODUCT (e.g., sumatriptan-naproxen, Symbravo):

Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS

Has a clinical reason why the INDIVIDUAL ACTIVE INGREDIENTS of the requested drug cannot be used concurrently

Also, for SYMBRAVO (meloxicam-rizatriptan):

Tried and failed or has a contraindication or an intolerance to SUMATRIPTAN-NAPROXEN tablet

7. For ALL OTHER NON-PREFERRED Migraine Acute Treatment Agents:

Tried and failed or has a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents

RENEWAL requests

Check all of the following that apply to the beneficiary and this request and **SUBMIT DOCUMENTATION** for each item.
Refer to <https://papdl.com/preferred-drug-list> for a list of preferred & non-preferred drugs in the Migraine Acute Treatment Agents class.

1. For ALL requests:

Experienced improvement in headache pain, symptoms, or duration

2. For a NON-PREFERRED TRIPTAN:

Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS

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

Tried and failed or has a contraindication or intolerance to the preferred GEPANTS

4. For a NON-PREFERRED NSAID (e.g., Elyxyb, diclofenac powder packet):

Tried and failed or has a contraindication or an intolerance to the preferred oral NSAIDs in the NSAIDs PDL class

5. For a NON-PREFERRED TRIPTAN-NSAID COMBINATION PRODUCT (e.g., sumatriptan-naproxen, Symbravo):

Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS

Has a clinical reason why the INDIVIDUAL ACTIVE INGREDIENTS of the requested drug cannot be used concurrently

Also, for SYMBRAVO (meloxicam-rizatriptan):

Tried and failed or has a contraindication or an intolerance to SUMATRIPTAN-NAPROXEN tablet

6. For ALL OTHER non-preferred Migraine Acute Treatment Agents:

Tried and failed or has a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents

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.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the requested quantity/dose/frequency supported by current medical compendia and/or peer-reviewed medical literature?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>

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:

<input type="checkbox"/> anticonvulsant (e.g., topiramate, valproate derivative)	<input type="checkbox"/> beta blocker (e.g., metoprolol, propranolol, timolol)
<input type="checkbox"/> antidepressant (e.g., SNRI, TCA)	<input type="checkbox"/> CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
<input type="checkbox"/> other: _____	
- Tried and failed preventive migraine medications – specify:

<input type="checkbox"/> anticonvulsant (e.g., topiramate, valproate derivative)	<input type="checkbox"/> beta blocker (e.g., metoprolol, propranolol, timolol)
<input type="checkbox"/> antidepressant (e.g., SNRI, TCA)	<input type="checkbox"/> CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
<input type="checkbox"/> other: _____	
- Has an intolerance or a contraindication to preventive migraine medications – specify:

<input type="checkbox"/> anticonvulsant (e.g., topiramate, valproate derivative)	<input type="checkbox"/> beta blocker (e.g., metoprolol, propranolol, timolol)
<input type="checkbox"/> antidepressant (e.g., SNRI, TCA)	<input type="checkbox"/> CRGP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
<input type="checkbox"/> other: _____	

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

Prescriber Signature:	Date:
------------------------------	--------------

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.