MIGRAINE ACUTE TREATMENT AGENTS PRIOR AUTHORIZATION FORM





(form effective 1/6/2025)

Fax to PerformRx[™] at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHO	DRIZATION REQUE	EST INFORMATION					
	Renewal request	Total # of pages:					
Name of office contact:		Contact's phone number:		LTC facility contact/phone:			
PATIENT INFO	RMATION						
Patient name:			Pat	ient ID #:			DOB:
Street address:					-		
Apt #:	City/state/zip:				Phone:		
PRESCRIBER I	INFORMATION						
Prescriber name:							
Specialty:			NPI:			State license #:	
Street address:							
Suite #:	City/state/zip:						
Phone:			Fax:				
CLINICAL INFO	ORMATION						
Refer to https://pap	dl.com/preferred-drug-l	l ist for a list of preferred and non-p	preferred drugs in	this class			
Preferred:			No	n-Preferre	d:		
🗆 Eletriptan Tablet		Sumatriptan Pen Injector		Almotripta	n Tablet	[🗆 Migranal Nasal Spray
🗆 Naratriptan Tablet	t	🗆 Sumatriptan Tablet		Diclofenac	Potassium Powder Packet	[□ Relpax Tablet
Nurtec (rimegepant) ODT		🗆 Sumatriptan Vial		Dihydroergotamine Mesylate Ampule		0	Reyvow Tablet
🗆 Rizatriptan ODT		□ Ubrelvy Tablet		Dihydroer	gotamine Mesylate Nasal Sp	oray [□ Sumatriptan-Naproxen Tablet
🗆 Rizatriptan Tablet		🗆 Zolmitriptan ODT		Elyxyb Sol	ution	[□ Tosymra Nasal Spray
🗆 Sumatriptan Cartr	ridge	🗆 Zolmitriptan Tablet		🗆 Frova Tablet		[□ Trudhesa Nasal Spray
🗆 Sumatriptan Nasa	al Spray			🗆 Frovatriptan Tablet		[□ Zavzpret Nasal Spray
				Imitrex Ca	0		□ Zembrace Symtouch
				Imitrex Pe	•		Zolmitriptan Nasal Spray
				Imitrex Tal			□ Zomig Nasal Spray
				Maxalt Tab			☐ Zomig Tablet
				Maxalt ML	Т		
Strength and dosage	e form:			0 11			N 611
Dose/directions:				Quantity:			Refills:
Diagnosis (<u>submit do</u>							Dx code <u>(required)</u> :
INITIAL REQU	ESTS						
lf	the requested prescripti	Please complete either the ion exceeds the quantity limits/d				rs/dail	Y DOSE LIMITS section.
	ERRED MIGRAINE ACUTE		,	,	·····		
□ For a non-pre		ication or an intolerance to the prefe					
(Refer to	o https://papdl.com/prefen	red-drug-list for a list of preferred a		triptans in	the Migraine Acute Treatme	ent Agen	ts class.)
List med	dications tried:						
Tried and fa	ailed or has a contraindicat	tion or an intolerance to the preferre		r 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.)							
List medications tried: For a GEPANT/SMALL MOLECULE CGRP INHIBITOR (e.g., Nurtec ODT, Ubrelvy)							
		g., rizatriptan, sumatriptan, etc.) or h		tion or into	lerance to triptans		

INITIAL REQUESTS

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)	
List medications tried:	
\Box Tried and failed or has a contraindication or intolerance to the following:	
□ caffeine/analgesic combination (e.g., Excedrin)	
🗆 triptans	
\Box 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 fo tricture in the Minute Acate Tractage Acate Leas)	r 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	r a list of preferred and non-preferred
gepants in the Migraine Acute Treatment Agents class.)	
List medications tried:	
□ For ALL OTHER non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, et	
Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class that are approved or medically accepted drug in the Migraine Andre Treatment of a preferred drug in the Migraine Andre Treatm	
diagnosis (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in the Migraine Acute Treatmer	it Ageins class.)
QUANTITY LIMITS/DAILY DOSE LIMITS REQUESTS	
All requests that exceed the quantity limits/daily dose limits require prior authorization.	
Is the requested medication prescribed by a neurologist or specialist certified in headache medicine by the United Council for Neurologic Subsp	
Is the requested medication prescribed by a neurologist or specialist certified in headache medicine by the United Council for Neurologic Subsp Is the requested quantity/dose/frequency supported by current medical compendia and/or peer-reviewed medical literature? \Box Yes \Box No S	
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