

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

ACUTE MIGRAINE

D.H.E 45[®], Migranal[®], Nurtec[™], Reyvow[™], Treximet[®], Ubrelvy[®], Zavzpret[™]

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:

Preferred: generic triptan medications (e.g., almotriptan, sumatriptan, rizatriptan), Ubrelvy[®] (ubrogepant)

Non-Formulary: dihydroergotamine mesylate injection, dihydroergotamine mesylate nasal spray, Nurtec[™] (rimegepant) ODT, Reyvow[™] (lasmimiditan), Treximet[®] (sumatriptan and naproxen sodium), Zavzpret[™] (zavegepant) nasal spray

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, a neurologist or headache specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a documented diagnosis of migraine with or without aura?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does clinical documentation show either: <ul style="list-style-type: none"> • Member has less than 15 headache days per month? • Member has \geq 15 headache days per month AND taking a prophylactic agent (e.g. an antidepressant, anticonvulsant, beta-blocker, Botox[®], or calcium channel blocker)? 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member had a trial and failure or contraindication/intolerance to at least two preferred generic triptan medications taken at the maximum FDA-approved dosage in both an oral formulation AND either a nasal spray or subcutaneous injection? (e.g. sumatriptan, rizatriptan, zolmitriptan) ?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. For non-formulary medications, has the member had a trial and failure of Ubrelvy [®] ?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

6. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication to prevent migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
DIHYDROERGOTAMINE MESYLATE NASAL SPRAY			
1. Has the member had a trial and failure, or intolerance, to dihydroergotamine injection?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
TREXIMET			
1. Has the member tried and found to be intolerant to the inactive ingredients in both naproxen sodium and sumatriptan?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show the member has a positive clinical response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication to prevent migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request. ****

Policy: PHARM-CHIP-088
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

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