HEALTHY U MEDICAID

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 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-Preferred: ☐ Nurtec™ (rimegepant)
Non-Formulary: ☐ dihydroergotamine mesylate injection, ☐ dihydroergotamine mesylate nasal spray, ODT, ☐ Reyvow™ (lasmmiditan), ☐ 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?	☐	☐	
2. Does the member have a documented diagnosis of migraine with or without aura?	☐	☐	**Please provide documentation**
3. Does clinical documentation show either: • Member has less than 15 headache days per month? • Member has ≥ 15 headache days per month AND taking a prophylactic agent (e.g. an antidepressant, anticonvulsant, beta-blocker, Botox®, or calcium channel blocker)?	☐	☐	**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, zolitriptan)?	☐	☐	**Please provide documentation**
5. For non-preferred medications, has the member had a trial and failure of Ubrelvy®?	☐	☐	**Please provide documentation**

6. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication to prevent migraine headaches?	☐	☐	**Please provide documentation**
DIHYDROERGOTAMINE MESYLATE NASAL SPRAY			
1. Has the member had a trial and failure, or intolerance, to dihydroergotamine injection?	☐	☐	**Please provide documentation**
TREXIMET			
1. Has the member tried and found to be intolerant to the inactive ingredients in both naproxen sodium and sumatriptan?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show the member has a positive clinical response to therapy?	☐	☐	**Please provide documentation**
3. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication to prevent migraine headaches?	☐	☐	**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:

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Policy PHARM-HU-088
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/27/2024
Next Review Date: 03/27/2025
Current Effective Date: 04/01/2024