# PRIOR AUTHORIZATION REQUEST FORM

Virginia Premier Anti-Migraine Preferred

**Phone: 800-727-7536** **Fax back to: 833-770-7569**

Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

| **Patient Name:** | **Prescriber Name:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Group Number: | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | Specialty/facility name (if applicable): | |

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For continuing therapy, please specify start date (MM/YY). If the request is for continuing therapy and the requested medication was approved by a previous Health Plan, please submit documentation of the previous approval to be considered.

Q3. Please indicate the patient's diagnosis for the requested medication:

- ☐ Preventative treatment of migraine
- ☐ Acute treatment of migraine
- ☐ Treatment of episodic cluster headache
- ☐ Other

Q4. If the patient’s diagnosis is OTHER, please specify below:

Q5. Has the patient had trial and failure of two generic triptans? Please select all that apply:

- ☐ Eletriptan
- ☐ Naratriptan
- ☐ Rizatriptan
- ☐ Sumatriptan
- ☐ Zolmitriptan

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☐ Other
☐ None of the above

Q6. If the medication is OTHER, please specify below:

Q7. If the patient has NOT tried any of the medications listed in the previous question, is there a reason why these medications cannot be used (i.e., contraindication, history of adverse event, etc.)?

Q8. Does the member have a diagnosis of migraine with or without aura base on International Classification of Headache Disorders (ICHD-III) diagnostic criteria?

☐ Yes ☐ No

Q9. For which of the following is the member using this medication? Check all that apply.

☐ Preventative treatment of migraine
☐ Acute treatment of migraine
☐ Treatment of episodic cluster headache
☐ Other use

Q10. For OTHER USE, specify details:

Q11. Is the member 18 years of age or older?

☐ Yes ☐ No

Q12. Can you confirm that the member does not have medication over-use headache (MOH)?

☐ Yes ☐ No

Q13. If the member is a woman of childbearing age, has the member had a pregnancy test at baseline?

☐ Yes ☐ No ☐ Not applicable

Q14. Has the member tried and failed a greater than or equal to 1 month trial of any 2 of the following oral medications?

☐ Antidepressants (e.g., amitriptyline, venlafaxine)
☐ Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
☐ Anti-epileptics (e.g., valproate, topiramate)
☐ Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril,candesartan)

Q15. For RENEWAL, did the member demonstrated significant decrease in the number, frequency, and/or intensity of headaches?

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| | | |
|---|---|---|
| ☐ Yes | ☐ No | |
| Q16. For RENEWAL, has the member experienced an overall improvement in function with therapy? | | |
| ☐ Yes | ☐ No | |
| Q17. For RENEWAL, does the member continue to utilize prophylactic intervention modalities (e.g., behavioral therapy, physical therapy, life-style modification)? | | |
| ☐ Yes | ☐ No | |
| Q18. For RENEWAL, if the member is a woman of childbearing age, will the member continue to be monitored for pregnancy status? | | |
| ☐ Yes | ☐ No | ☐ Not applicable |
| Q19. For RENEWAL, does the member have an absence of unacceptable toxicity (e.g., intolerable injection site pain or constipation)? | | |
| ☐ Yes | ☐ No | |

Prescriber Signature

Date