

Pharmacy Prior Authorization Form

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Migraine Abortive Medication- Supplemental Supply

Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Medication Requested:

Dose:

Background¹: Prophylactic migraine treatment is indicated if the headaches are frequent, long lasting, or account for a significant amount of total disability. The AAN practice parameter² notes that the goals of preventive therapy are to:

- Reduce attack frequency, severity and duration
- Improve responsiveness to treatment of acute attacks
- Improve function and reduce disability

The following factors may indicate the need for prophylactic therapy:

- Recurring migraines that significantly interfere with daily routine in the patient's opinion, despite acute treatment
- Contraindication to or failure or overuse of acute therapies
- Adverse events with acute therapies
- Patient preference

Based on expert consensus, prophylactic therapy also should be considered to prevent neurologic damage in the presence of uncommon migraine conditions including:

- Hemiplegic migraine
- Basilar type migraine
- Migraine with prolonged aura
- Migrainous infarction

Priority Health precertification requirements:

Quantity limits for migraine abortive medications:

- Authorization of Imitrex is limited to:
 - 18 tablets per 30 days
 - 6 injections (3 mls) per 30 days
 - 2 nasal spray boxes per 30 days (20 mg)
 - 4 nasal spray boses per 30 days (40 mg)
- Authorization of Maxalt and Zomig is limited to:
 - 18 tablets per 30 days
- Authorization of Relpax is limited to:
 - 12 tablets per 30 days

Requests for quantity overrides require:

- Patient must be receiving at least one prophylactic agent

Please Complete the Following Information:

Request is for quantity override:

- Yes – Quantity requested: _____
- No

If requesting quantity override, patient is taking one of the following prophylactic therapies (check which applies):

Beta Blockers

- atenolol
- metoprolol
- nadolol
- propranolol
- timolol maleate

Anticonvulsants

- divalproex sodium (Depakote)
- valproic acid (Depakene)
- topiramate (Topamax)
- gabapentin

Calcium Channel Blockers

- diltiazem
- nimodipine
- verapamil HCl

Tricyclic Antidepressants

- amitriptyline
- doxepine
- imipramine

Duration of approval:

- When approved, authorization will be granted for one year
- Continued authorization requires patient to be compliant with prophylactic therapy

References:

1. UpToDate. Preventive Treatment of Migraines in Adults. Accessed October 19, 2007.
2. Silberstein, SD. Practice parameter: evidence-based guidelines for migraine headache (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2000; 55:754.

For Medicare only: If none of the above is applicable to this member, please check which, if any, of the following apply:

- All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
- The number of doses available under a dose restriction for the prescription drug:
 - Has been ineffective in the treatment of the enrollee's disease or medical condition or,
 - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance
- The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

- Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
- None of the above apply

*** All fields must be complete and legible for Prior Authorization Review***
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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX