

PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Dihydroergotamine Nasal Spray

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

T ELACE NOTE: Any information (patient, processing, aray, labor for status, megiste, or not attached will actual the forests.		
Patient Name:	Prescriber Name:	
Member Number:	Fax: Phone:	
Date of Birth:	Office Contact:	
Line of Business: Exchange - PA	NPI: State Lic ID:	
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box and signithe enrollee or the enrollee's ability to regain maximum function.	ing below, I certify that the standard review timeframe may seriously jeopardize the life or health of	
Drug Name:		
Strength:		
Directions / SIG:		
Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.		
Q1. Is there confirmation that the drug will not be used for prophylactic migraine therapy?		
☐ Yes	□ No	
Q2. Is this medication being used for the aura?	acute treatment of migraine headaches with or without	
☐ Yes	□ No	
Q3. Is this member 18 years of age or old	der?	
☐ Yes	□ No	
Q4. Is this medication being prescribed b specialist, or pain specialist?	y or in consultation with a neurologist, headache	
☐ Yes	□ No	
Q5. Is there documentation showing an inadequate response, intolerance, or contraindication to two generic triptans (such as sumatriptan, zolmitriptan, rizatriptan)?		

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Dihydroergotamine Nasal Spray

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:	
☐ Yes	□ No	
Q6. Is there documentation showing an inadequate response, inability to tolerate or contraindication to one generic triptan AND gepant?		
☐ Yes	□ No	
Q7. Have all potential contraindications (including uncontrolled hypertension, use as management of hemiplegic basilar migraine, ischemic heart disease (angina pectoris, history of myocardial infarction, or documented silent ischemia) or coronary artery vasospasm including Prinzmetal's variant angina, coadministration with CYP3A4 inhibitors or peripheral and central vasoconstrictors, concomitant use or use within 24 hours of ergotamine containing or ergot type medications or methysergide, peripheral arterial disease, sepsis, following vascular surgery, severely impaired hepatic or renal function, hypersensitivity to ergot alkaloids) been excluded?		
☐ Yes	□ No	
Q8. Additional Information:		
Prescriber Signature	Date	

v2025