HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Migraine Acute Treatment Agents

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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. The request is for a Migraine Acute Treatment Agent that was previously approved. If YES, go to 17.

☐ Yes ☐ No

Q2. The request is for a gepant for the preventive treatment of migraine. If YES, see the prior authorization guideline related to Migraine Prevention Agents.

☐ Yes ☐ No

Q3. The member meets all of the following:

☐ Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication

☐ Has a diagnosis confirmed according to the current International Headache Society Classification of Headache Disorders

☐ Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Does not have a contraindication to the prescribed drug

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Member Name:	Prescriber Name:

Q4. For a gepant for the acute treatment of migraine, one of the following:

. Has a history of therapeutic failure of at least two (5-HT 1B/1D) receptor agonists (triptans)

. Has a contraindication or an intolerance to the preferred triptans

If YES, go to 8.

☐ Yes ☐ No ☐ NA

Q5. For a ditan, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred triptans.

If YES, go to 12.

☐ Yes ☐ No ☐ NA

Q6. For an ergot alkaloids, has a history of therapeutic failure of or a contraindication or an intolerance to standard first-line abortive drugs based on headache classification as recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society).

If YES, go to 12.

☐ Yes ☐ No ☐ NA

Q7. For a non-preferred triptan, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred triptans.

If YES, go to 12.

☐ Yes ☐ No ☐ NA

Q8. For a non-preferred gepant, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred gepants.

If YES, go to 12.

☐ Yes ☐ No ☐ NA

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Member Name:	Prescriber Name:

Q9. For a non-preferred non-steroidal anti-inflammatory drug (NSAID) (e.g., Elyxyb [celecoxib] solution, diclofenac potassium powder packet), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred oral NSAIDs (excluding ketorolac) approved or medically accepted for the beneficiary's diagnosis in the NSAIDs Statewide PDL class.

If YES, go to 12.

☐ Yes ☐ No ☐ NA

Q10. For a non-preferred triptan-NSAID combination product, all of the following:

. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred triptans,

. Has a clinical reason as documented by the prescriber why the individual active ingredients cannot be used concurrently,

. In addition, for Symbravo (meloxicam-rizatriptan), has a history of therapeutic failure of or a contraindication or an intolerance to sumatriptan-naproxen tablet

If YES, go to 12.

☐ Yes ☐ No ☐ NA

Q11. For non-preferred Migraine Acute Treatment Agents other than triptans, gepants, NSAIDs, and triptan-NSAID combination products (e.g., ditans, ergot alkaloids, etc.), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication.

☐ Yes ☐ No

Q12. If a prescription for a Migraine Acute Treatment Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the plan's quantity limit guidelines. If YES, go to 13.

☐ Yes ☐ No ☐ NA

Q13. The beneficiary is prescribed the requested drug by one of the following:

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Member Name:	Prescriber Name:

☐ A neurologist

☐ A headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)

Q14. For the acute treatment of migraine, the member is using the requested drug in addition to at least one drug for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody, gepant, botulinum toxin).

☐ Yes ☐ No

Q15. The member has a history of therapeutic failure of or a contraindication or an intolerance to all preventive migraine drugs recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society).

☐ Yes ☐ No

Q16. The member has documentation of an evaluation for the overuse of abortive drugs, including opioids.

☐ Yes ☐ No

Q17. The member meets both of the following:

☐ Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Does not have a contraindication to the prescribed drug

Q18. Documentation is attached showing improvement in headache pain, symptoms, or duration

☐ Yes ☐ No

Q19. For a non-preferred triptan, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred triptans. If YES, go to 24.

☐ Yes ☐ No ☐ NA

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Member Name:	Prescriber Name:

Q20. For a non-preferred gepant, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred gepants. If YES, go to 24.

☐ Yes ☐ No ☐ NA

Q21. For a non-preferred NSAID (e.g., Elyxyb [celecoxib] solution, diclofenac potassium powder packet), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred oral NSAIDs (excluding ketorolac) approved or medically accepted for the beneficiary's diagnosis in the NSAIDs Statewide PDL class. If YES, go to 24.

☐ Yes ☐ No ☐ NA

Q22. For a non-preferred triptan-NSAID combination product, all of the following:

. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred triptans,
. Has a clinical reason as documented by the prescriber why the individual active ingredients cannot be used concurrently,
. In addition, for Symbravo (meloxicam-rizatriptan), has a history of therapeutic failure of or a contraindication or an intolerance to sumatriptan-naproxen tablet

If YES, go to 24.

☐ Yes ☐ No ☐ NA

Q23. For non-preferred Migraine Acute Treatment Agents other than triptans, gepants, NSAIDs, and triptan-NSAID combination products (e.g., ditans, ergot alkaloids, etc.), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Migraine Acute Treatment Agents approved or medically accepted for the beneficiary's diagnosis or indication.

☐ Yes ☐ No

Q24. If a prescription for a Migraine Acute Treatment Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the plan's quantity limit guidelines.

☐ Yes ☐ No ☐ NA

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Member Name:	Prescriber Name:

Q25. The beneficiary is prescribed the requested drug by one of the following:

☐ A neurologist

☐ A headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)

Q26. For the acute treatment of migraine, the member is using the requested drug in addition to at least one drug for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody, gepant, botulinum toxin). If YES, go to 28.

☐ Yes ☐ No

Q27. The member has a history of therapeutic failure of or a contraindication or an intolerance to all preventive migraine drugs recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society).

☐ Yes ☐ No

Q28. The member has documentation of an evaluation for the overuse of abortive drugs, including opioids.

☐ Yes ☐ No

Q29. Additional Information:

Prescriber Signature

Date

v2026

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