Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

MIGRAINE PREVENTION AGENTS (CALCITONIN GENE-RELATE

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.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: **Specialty/facility name (if applicable):**	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

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. Is the patient 18 years of age or older?
☐ Yes ☐ No

Q2. Does the patient have a diagnosis of migraine?
☐ Yes ☐ No

Q3. Is the medication being prescribed by or in consultation with a neurologist or headache specialist?
☐ Yes ☐ No

Q4. Has the diagnosis been confirmed based on the most current criteria from the International Classification of Headache Disorders?
☐ Yes ☐ No

Q5. Did the patient have 4 or more migraine days per month or headaches that lasted longer than 12 hours within the past 3 months? (Please provide documentation showing the number of monthly migraine headache days)
☐ Yes ☐ No

Q6. Has the patient tried and failed at least two formulary alternatives from different drug classes (such as Beta Blockers, Antidepressants, Anticonvulsants)? Please include documentation of agents used with doses, date/duration of use and specific outcomes or documentation of intolerance or contraindication to trying at least 2 formulary

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alternatives.

☐ Yes ☐ No

Q7. For patients diagnosed with chronic migraine experiencing ≥ 15 headache days per month- Has the patient tried treatment with Botox injections? Please include documentation of dose injected (up to 155 units per treatment), date/duration of use and specific outcome or documentation of intolerance or contraindication to treatment with Botox.

☐ Yes ☐ No

Q8. Is the dose prescribed consistent with FDA approved package labeling or nationally recognized compendia?

☐ Yes ☐ No

Q9. Requested Duration:

☐ 4 Months

Q10. Additional Information:

Prescriber Signature

Date

Updated 2018