Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antimigraine Agents - Other

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:	
Patient 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. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q2. Does the patient have a history of contraindication to the requested drug?

☐ Yes ☐ No

Q3. Is this a request for a calcitonin gene-related peptide (CGRP) antagonist?

☐ Yes ☐ No

Q4. Is the requested calcitonin gene-related peptide (CGRP) antagonist prescribed by or in consultation with a neurologist OR a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)?

☐ Yes ☐ No

Q5. Is the requested drug being prescribed for the prevention of migraine?

☐ Yes ☐ No

Q6. Has the patient had a reduction in the average number of migraine days or headache days per month from baseline?

☐ Yes ☐ No

Q7. Has the patient experienced a decrease in the severity or duration of migraines from baseline?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q8. Is the patient being prescribed a dose that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q9. Is the requested drug being prescribed for a diagnosis of episodic cluster headache?

☐ Yes ☐ No

Q10. Does the patient have documentation of a positive clinical response to the requested drug, as evidenced by a reduction in cluster headache frequency from baseline?

☐ Yes ☐ No

Q11. Is the patient being prescribed a dose and duration of therapy that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q12. Is this a request for an ergot alkaloid?

☐ Yes ☐ No

Q13. Has the patient experienced an improvement in headache pain control or duration?

☐ Yes ☐ No

Q14. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package insert OR a medically accepted indication?

☐ Yes ☐ No

Q15. Is the requested drug age appropriate for the patient according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q16. Does the patient have a history of contraindication to the requested drug?

☐ Yes ☐ No

Q17. Will the patient be using the requested drug with another calcitonin gene-related peptide (CGRP) antagonist?

☐ Yes ☐ No

Q18. Does the patient have a diagnosis of migraine with or without aura confirmed according to the current International Headache Society Classification of Headache Disorders?

☐ Yes ☐ No

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Q19. Does the patient have documentation of the baseline average number of migraine days and headache days per month?

☐ Yes ☐ No

Q20. Has the patient averaged four or more migraine days per month over the previous three months?

☐ Yes ☐ No

Q21. Does the patient have a history of therapeutic failure of at least one preventive drug from TWO of the following drug classes: A) beta blockers (e.g., metoprolol, propranolol, timolol), B) antidepressants (e.g., amitriptyline, venlafaxine), C) anticonvulsants (e.g., topiramate, valproic acid, divalproex)?

☐ Yes ☐ No

Q22. Does the patient have a history of a contraindication to or intolerance of all of the preventive drugs from ALL of the following drug classes: A) beta blockers (e.g., metoprolol, propranolol, timolol), B) antidepressants (e.g., amitriptyline, venlafaxine), C) anticonvulsants (e.g., topiramate, valproic acid, divalproex)?

☐ Yes ☐ No

Q23. Is this a request for a preferred calcitonin gene-related peptide (CGRP) antagonist?

☐ Yes ☐ No

Q24. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred calcitonin gene-related peptide (CGRP) antagonists approved or medically accepted for the patient's diagnosis?

☐ Yes ☐ No

Q25. Does the patient have a diagnosis of episodic cluster headache confirmed according to the current International Headache Society Classification of Headache Disorders?

☐ Yes ☐ No

Q26. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of at least one other preventive drug recommended by current consensus guidelines for episodic cluster headache (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society)?

☐ Yes ☐ No

Q27. Does the patient have a diagnosis of headache based on the current International Headache Society Classification of Headache Disorders?

☐ Yes ☐ No

Q28. Does the patient have a documented history of trial and failure, contraindication to, or intolerance of standard first-line abortive medications 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)?

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Patient Name:	Prescriber Name:

☐ Yes	☐ No
Q29. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2020