



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Migraine Prevention 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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, Strength, Refills, Specialty Pharmacy.

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.

Questions Q1-Q7 regarding authorization renewal, contraindications, prescriber qualifications, and patient response to treatment.

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Patient Name: Prescriber Name:

Q8. 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?
Q9. 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?
Q10. Will the patient be using the requested Migraine Prevention Agent with another Migraine Prevention agent or small molecule CGRP receptor antagonist (gepant)?
Q11. 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?
Q12. 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?
Q13. 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?
Q14. Does the patient have a history of contraindication to the requested drug?
Q15. Is the requested Migraine Prevention Agent 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)?
Q16. Is the requested drug being prescribed for the prevention of migraine?
Q17. Does the patient have a diagnosis of migraine with or without aura confirmed according to the current International Headache Society Classification of Headache Disorders?
Q18. Does the patient have documentation of the baseline average number of migraine days and headache days per month?

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Patient Name: Prescriber Name:

Q19. Has the patient averaged four or more migraine days per month over the previous three months?
Q20. 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)?
Q21. 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)?
Q22. Is the requested drug being prescribed for a diagnosis of episodic cluster headache?
Q23. Does the patient have a diagnosis of episodic cluster headache confirmed according to the current International Headache Society Classification of Headache Disorders?
Q24. 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)?
Q25. Is the request for a non-preferred Migraine Prevention Agent?
Q26. Does the patient have a documented history or therapeutic failure, contraindication, or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the patient's diagnosis?
Q27. Will the patient be using the requested Migraine Prevention Agent with another Migraine Prevention agent or small molecule CGRP receptor antagonist (gepants)?
Q28. Additional Information:



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Patient Name:	Prescriber Name:
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Prescriber Signature

Date

*Updated for 2021*