Health Partners Plans

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.

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 a prior authorization?

☐ Yes ☐ No

Q2. Is the requested medication being used to treat a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q3. Does the patient have a confirmed diagnosis according to the current International Headache Society Classification of Headache Disorders?

☐ Yes ☐ No

Q4. Is the patient age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Is the prescribed dose for the requested medication consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q6. Does the patient have a history of contraindication to the prescribed medication?

☐ Yes ☐ No

Q7. Is the request for a small molecule calcitonin gene-related peptide (CGRP) receptor antagonist (gepant)?

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☐ Yes ☐ No

Q8. Does the patient have a history of therapeutic failure of at least two (5-HT 1B/1D) receptor agonists (triptans)?

☐ Yes ☐ No

Q9. Does the patient have a history of contraindication or intolerance to the preferred triptans?

☐ Yes ☐ No

Q10. Will the patient be using the requested gepant with another gepant or a CGRP monoclonal antibody?

☐ Yes ☐ No

Q11. Is the request for a serotonin (5-HT) 1F receptor agonist (ditan)?

☐ Yes ☐ No

Q12. Does the patient have a history of contraindication or intolerance to the preferred triptans?

☐ Yes ☐ No

Q13. Is the request for an ergot alkaloid?

☐ Yes ☐ No

Q14. Does the patient have a history of trial and failure, contraindication, or intolerance to 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)?

☐ Yes ☐ No

Q15. Is this a request for a triptan antimigraine agent when there is a recent paid claim for another triptan antimigraine agent (i.e., potential therapeutic duplication)?

☐ Yes ☐ No

Q16. Is the patient being titrated to or tapered from another drug in the same class?

☐ Yes ☐ No

Q17. Has the prescriber provided supporting peer reviewed literature or national treatment guidelines to corroborate concomitant use of the medications being requested?

☐ Yes ☐ No

Q18. Is this a request for a Migraine Acute Treatment Agent that exceeds the quantity limit?

☐ Yes ☐ No

Q19. Does the patient meet all of the following? A.Health Partners plans quantity limit guidelines; B. The prescriber is a

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neurologist OR headache specialist who is certified in headache medicine by the UCNS; C. For acute treatment of migraine both of the following: I. The medication will be used in addition to at least one medication for migraine prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody); OR there is a history of therapeutic failure, contraindication, or intolerance to all preventative migraine medications recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society); II. Documentation of an evaluation for the overuse of abortive medications, including opioids.

☐ Yes ☐ No

Q20. Is this a request for a preferred triptan antimigraine agent?

☐ Yes ☐ No

Q21. Is the request for a non-preferred triptan?

☐ Yes ☐ No

Q22. Does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred triptans?

☐ Yes ☐ No

Q23. For all other non-preferred Migraine Acute Treatment Agents, does the patient have a history of therapeutic failure, contraindication to, or intolerance of the preferred Migraine Acute Treatment Agents approved or medically accepted for the patient's diagnosis?

☐ Yes ☐ No

Q24. Is the prescribed dose for the requested medication consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q25. For a gepant, will the patient be using the requested gepant with another gepant or a CGRP monoclonal antibody?

☐ Yes ☐ No

Q26. Is there documentation of improvement in headache pain, symptoms, or duration?

☐ Yes ☐ No

Q27. Is this a request for a Migraine Acute Treatment Agent that exceeds the quantity limit?

☐ Yes ☐ No

Q28. Does the patient meet all of the following? A. Health Partners plans quantity limit guidelines; B. The prescriber is a neurologist OR headache specialist who is certified in headache medicine by the UCNS; C. For acute treatment of migraine both of the following: I. The medication will be used in addition to at least one medication for migraine

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prevention (e.g., beta-blocker, anticonvulsant, antidepressant, CGRP monoclonal antibody); OR there is a history of therapeutic failure, contraindication, or intolerance to all preventative migraine medications recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society); II. Documentation of an evaluation for the overuse of abortive medications, including opioids.

☐ Yes ☐ No

Q29. Additional Information:

Prescriber Signature _____ Date _____

Updated for 2021

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