Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

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.

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 contraindication to the requested drug?

☐ Yes ☐ No

Q3. 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)?

☐ Yes ☐ No

Q4. Is the requested drug being prescribed for the prevention of migraine?

☐ Yes ☐ No

Q5. Has the patient had a reduction in the average number of migraine days or headache days per month from baseline?

☐ Yes ☐ No

Q6. Has the patient experienced a decrease in the severity or duration of migraines from baseline?

☐ Yes ☐ No

Q7. Is the requested drug being prescribed for a diagnosis of episodic cluster headache?

☐ Yes ☐ No

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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?

☐ Yes ☐ No

Q9. For Nurtec ODT for the prevention of migraine, has a documented history of therapeutic failure, contraindication, or intolerance to the preferred CGRP mAbs approved or medically accepted for the indication?

☐ Yes ☐ No

Q10. 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

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?

☐ Yes ☐ No

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?

☐ Yes ☐ No

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?

☐ Yes ☐ No

Q14. Does the patient have a contraindication to the requested drug?

☐ Yes ☐ No

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)?

☐ Yes ☐ No

Q16. Is the requested drug being prescribed for the prevention of migraine?

☐ Yes ☐ No

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?

☐ Yes ☐ No

Q18. Does the patient have documentation of the baseline average number of migraine days and headache days per month?

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☐ Yes	☐ No
Q19. Has the patient averaged four or more migraine days per month over the previous three months?	
☐ Yes	☐ No
Q20. Does the patient have a history of therapeutic failure of at least one preventive drug from TWO of the following three 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
Q21. Does the patient have a contraindication or intolerance that prohibits a trial of at least one preventive drugs from two of the following three 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. Is the requested drug being prescribed for a diagnosis of episodic cluster headache?	
☐ Yes	☐ No
Q23. Does the patient have a diagnosis of episodic cluster headache confirmed according to the current International Headache Society Classification of Headache Disorders?	
☐ Yes	☐ No
Q24. Does the patient have a documented history of therapeutic failure, contraindication , 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
Q25. If currently using a Migraine Prevention Agent for the preventive treatment of migraine or the treatment of episodic cluster headaches, one of the following: a) will discontinue use of that Migraine Prevention Agent prior to starting the requested Migraine Prevention Agent; b) has medical reason for concomitant use of both Migraine Prevention Agents that is supported by peer-reviewed literature or national treatment guidelines?	
☐ Yes	☐ No
Q26. For a gepant, if currently using a different gepant, one of the following: a) Will discontinue use of that gepant prior to starting the requested gepant; b) Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines?	
☐ Yes	☐ No
Q27. For Nurtec ODT for the prevention of migraine, has a documented history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for the indication?	

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☐ Yes	☐ No
Q28. Is the request for a non-preferred Migraine Prevention Agent?	
☐ Yes	☐ No
Q29. 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 or indication?	
☐ Yes	☐ No
Q30. Additional Information:	

Prescriber Signature

Date

Updated for 2022