

# ACUTE MIGRAINE PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermy meds.com](http://covermy meds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

**Today’s Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today’s Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient’s Diagnosis: <input type="checkbox"/> Acute migraine treatment <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was the treatment started on samples? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ _____	
2. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____ _____	
3. Is the patient’s age within FDA labeling for the requested indication for the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, is there support for using the requested agent for the patient’s age for the requested indication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide supporting information: _____ _____	
4. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). <b>Please note, documentation may be required:</b> _____ _____ _____ _____	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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5. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? .....  Yes  No  
 If yes, does the patient have greater than 4 migraine headaches per month? .....  Yes  No  
 If yes, is there support for therapy with a higher dose for the requested indication? .....  Yes  No  
 If yes, please provide supporting information: \_\_\_\_\_

If no, is the patient currently being treated with a migraine prophylactic medication (i.e. anticonvulsants [divalproex, valproate, topiramate], beta blockers [i.e. atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [i.e. amitriptyline, venlafaxine], candesartan, prophylactic CGRP [e.g. Aimovig, Ajovy, Emgality, Nurtec, Qulipta, Vyepti], onabotulinum toxin A [Botox])?.....  Yes  No  
 If yes, please specify: \_\_\_\_\_

If no, does the patient have an intolerance or hypersensitivity to therapy with anticonvulsants, beta blockers, antidepressants, candesartan, prophylactic CGRP, AND onabotulinum toxin A?.....  Yes  No  
 If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_

If no, does the patient have an FDA labeled contraindication to ALL anticonvulsants, beta blockers, antidepressants, candesartan, prophylactic CGRP, AND onabotulinum toxin A?.....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_

**For acute migraine treatment requests:**

6. Has medication overuse headache been ruled out? .....  Yes  No

7. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? .....  Yes  No

If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?.....  Yes  No

If no, has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer?.....  Yes  No

If yes, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?.....  Yes  No

8. Has the patient tried and had an inadequate response to ONE triptan agent? .....  Yes  No

If yes, please specify: \_\_\_\_\_

If no, does the patient have an intolerance or hypersensitivity to ONE triptan agent? .....  Yes  No

If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_

If no, does the patient have an FDA labeled contraindication to ALL triptan agents? .....  Yes  No

If yes, please specify FDA labeled contraindications: \_\_\_\_\_

9. Is the request for REYVOW?.....  Yes  No

If yes, will the patient be using the requested agent in combination with another acute migraine therapy (i.e., 5HT-1F, acute use CGRP, ergotamine) for the requested indication? .....  Yes  No

**For renewal requests:**

10. Has the patient had clinical benefit with the requested agent? .....  Yes  No

**Please fax or mail this form to:**

Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road  
 Eagan, MN 55121

**TOLL FREE**

**Phone:**

**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

**Fax: 877.243.6930**

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