Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
ACUTE MIGRAINE TREATMENTS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

No prior authorization (PA) is required for preferred acute migraine treatments, as indicated on the Preferred Drug List (PDL). PA is required for acute migraine treatments under the following conditions: 1) A diagnosis of acute migraine; and 2) Patient meets the FDA approved age for requested agent; and 3) For preferred acute migraine treatments where PA is required, as indicated on the PDL, documentation of previous trials and therapy failures with two preferred agents that do not require PA; and/or 4) For non-preferred acute migraine treatments, documentation of previous trials and therapy failures with two preferred agents that do not require PA. Requests for non-preferred CGRP inhibitors will also require documentation of a trial and therapy failure with a preferred CGRP inhibitor; and/or 5) For quantities exceeding the established quantity limit for each agent, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications; and/or 6) For non-preferred combination products, documentation of separate trials and therapy failures with the individual ingredients, in addition to the above criteria for preferred or non-preferred acute migraine treatments requiring PA. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred 5-HT1- Receptor Agonists
(PA required after 12 doses in 30 days)

- ☐ Imitrex NS
- ☐ Naratriptan
- ☐ Rizatriptan ODT
- ☐ Rizatriptan Tablets
- ☐ Sumatriptan Inj
- ☐ Sumatriptan NS
- ☐ Sumatriptan Tablets
- ☐ Zolmitriptan Tabs

Non- Preferred 5-HT-1 Receptor Agonists
(PA required from Day 1)

- ☐ Almotriptan
- ☐ Amerge
- ☐ Eletriptan
- ☐ Frova
- ☐ Frovatriptan
- ☐ Imitrex Inj/Tabs
- ☐ Maxalt
- ☐ Maxalt MLT
- ☐ Onzetra Xsail
- ☐ Relpax
- ☐ Reyvow
- ☐ Sumansetron
- ☐ Sumatriptan-Naproxen
- ☐ Tosymra
- ☐ Treximet
- ☐ Zembrace
- ☐ Zolmitriptan NS
- ☐ Zomig NS
- ☐ Zomig Tabs
- ☐ Zomig ZMT

Preferred CGRP Inhbitors
(PA required)

- ☐ Nurtec (Quantity limit 15 doses per 30 days)

Non-Preferred CGRP Inhibitors
(PA required)

- ☐ Ubrelvy

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:_____

Please document the current prophylactic therapy or 2 previous trials and therapy failures with two different prophylactic medications including drug names, strength, exact date ranges and failure reasons:

For Preferred Agents Requiring PA: document trials with two preferred agents that do not require PA

Preferred Trial 1: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Preferred Trial 2: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

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For Non-Preferred Agents Requiring PA: document trials with two preferred agents that do not require PA and a preferred GGRP inhibitor trial, if applicable

Preferred Trial 1: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Preferred Trial 2: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Preferred CGRP Inhibitor Trial: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

For quantities exceeding the established quantity limit: document current prophylactic therapy or previous trials and therapy failures with two different prophylactic medications

Preferred Prophylactic Trial 1: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Preferred Prophylactic Trial 2: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

For Non-Preferred Combination Products: document trials and therapy failures with the individual ingredients (in addition to above criteria for preferred or non-preferred treatments requiring PA)

Trial 1: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Trial 2: Name/Dose:_____ Trial Dates:_____

Failure reason:_____

Medical or contraindication reason to override trial requirements: _____

_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*