





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						DO	DOB											
Pa	tie	ent	ado	lress	 8																			
Provider NPI Prescriber name Phone																								
													1 100011001 110	uo					1 1.0					
Prescriber address													Fax	Fax										
Pharmacy name										Address							Pho	Phone						
Pr	es	cri	ber	mus	t c	omp	le	te a	all ir	nfor	mat	ion	above. It mus	st be	e legible, correct,	and co	mple	e or f	orm w	ill be	retur	ned.		
Ph	aı	rma	асу	NPI	1					1			Pharmacy fa	ΙX			NDC	1	1 1				1 1	
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 the use of these agents would be medically contraindicated.																								
Frovatriptan S					ays)] Su] Su				Non-Preferred 5-HT1 - Receptor Ago (PA required from Day 1) Almotriptan Maxalt Maxalt Mills Mills Maxalt Mills Maxalt Mills Maxalt Mills Mil			☐ Tosymra //LT ☐ Zembrace ☐ Zolmitriptan NS ☐ Zomig NS otan-Naproxen ☐ Zomig Tabs												
Preferred CGRP Inhibitors (PA required) Nurtec (Quantity limit 15 doses per 30 days) Ubrelvy (Quantity limit 16 doses per 30 days)								Non-Preferred CGRP Inhibitors (PA required) Zavzpret																
	Strength						Dosage Instru							ntity		Days Supply								
— Dia	gı	10:	sis:																					
															2 previous trials igth, exact date							diffe	rent	
For	P	re	ferr	ed A	١g	ents	R	eq	uiri	ng	PA:	do	ocument tria	ls w	vith two preferre	ed age	nts tl	nat do	not	requi	re P	A		
Preferred Trial 1: Name/Dose:												Trial Dates:												
Fail	ur	e r	eas	on:																				
Pre	fe	rre	d Tı	rial 2	2: 1	lam	e/[Dos	se: .									_ Tri	al Dat	es: _				
Fail	ur	e r	eas	on:																				

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For Non-Preferred Agents Requiring PA: document trials with two preferred GGRP inhibitor trial, if applicable	preferred agents that do not require PA and a
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 therapy failures with two different prophylactic medications	current prophylactic therapy or previous trials and
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 the	
addition to above criteria for preferred or non-preferred treatments	
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	f 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 Health and Human Services, that the member continues to be eligible for Medicaid.

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