FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR MIGRAINE AGENTS, INJECTABLE

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Injectable Completion Instructions, F-00622A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/subsystem/publications/forwardhealthcommunications.aspx?panel=Forms* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Injectable form signed by the prescriber before submitting a PA request on the Portal or on paper. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. Refills

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to an oral sumatriptan product? ❑ Yes ❑ No

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the oral sumatriptan product was taken in the space provided.

15. Does the member have a medical condition(s) that prevents him or her from using an oral sumatriptan product? ❑ Yes ❑ No

If yes, list the medical condition(s) in the space provided.

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SECTION III — CLINICAL INFORMATION (Continued)

16. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction to a nasal sumatriptan product? ❑ Yes ❑ No

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the nasal sumatriptan product was used in the space provided.

17. Does the member have a medical condition(s) that prevents him or her from using a nasal sumatriptan product? ❑ Yes ❑ No

If yes, list the medical condition(s) in the space provided.

18. Has the member used a preferred injectable sumatriptan product and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction? ❑ Yes ❑ No

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates the preferred injectable sumatriptan product was used in the space provided.

19. Does the member have a medical condition(s) that prevents him or her from using a preferred injectable sumatriptan product? ❑ Yes ❑ No

If yes, list the medical condition(s) in the space provided.

20. Is member preference the reason why the member is unable to use a preferred injectable sumatriptan product? ❑ Yes ❑ No

SECTION IV — AUTHORIZED SIGNATURE

21. **SIGNATURE** — Prescriber	22. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

23. National Drug Code (11 Digits)	24. Days' Supply Requested (Up to 365 Days)

25. NPI

26. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

27. Place of Service

28. Assigned PA Number

29. Grant Date	30. Expiration Date	31. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

32. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

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