DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02371 (09/2018)

STATE OF WISCONSIN

FORWARDHEALTH

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR MIGRAINE AGENTS, CALCITONIN GENE-RELATED PEPTIDE (CGRP) ANTAGONISTS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Migraine Agents, Calcitonin Gene-Related Peptide (CGRP) Antagonists Instructions, F-02371A. Providers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage for the completion instructions.

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

SECTION I – MEMBER INFORMATION

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

2. Member ID 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 – Prescriber

11. Address – Prescriber (Street, City, State, Zip+4 Code)

12. Phone Number – Prescriber

SECTION III – CLINICAL INFORMATION – ALL REQUESTS

13. Diagnosis Code and Description

Note: A copy of the member's medical records must be submitted with the PA request, including the following:

- The member's medical work-up for migraines, including complete problem and medication list
- Details regarding previous medication use
- The member's current migraine treatment plan
- The average number of headache days and migraine days the member has per month

SECTION IV – CLINICAL INFORMATION – INITIAL REQUESTS ONLY

14. Is the member 18 years of age or older? ☐ Yes ☐ No

15. Has the prescriber evaluated and diagnosed the member as having a history of migraine, with or without aura, according to the International Classification of Headache Disorders, 3rd edition (ICHD-3) diagnostic criteria? ☐ Yes ☐ No

Continued

SECTION IV – CLINICAL INFORMATION – INITIAL REQUESTS ONLY (Continued)

16. Has the member experienced episodic migraines (less than 15 headache days per month with four to 14 migraine days per month) for three or more months? ☐ Yes ☐ No

    If yes, indicate the number of headache days and migraine days per month.

    Headache Days Per Month _____ Migraine Days Per Month _____

17. Has the member experienced chronic migraines (15 or more headache days per month with eight or more migraine days per month) for three or more months? ☐ Yes ☐ No

    If yes, indicate the number of headache days and migraine days per month.

    Headaches Days Per Month _____ Migraine Days Per Month _____

18. Has the prescriber confirmed the member's headaches are not due to medication overuse or attributed to another causative disorder? ☐ Yes ☐ No

19. Has the prescriber discussed alternative non-pharmacological treatment options with the member, such as behavioral therapies, physical therapies, and lifestyle modifications? ☐ Yes ☐ No

Continued

SECTION IV – CLINICAL INFORMATION – INITIAL REQUESTS ONLY (Continued)

20. Check the boxes next to the drug categories from which the member has tried migraine prophylaxis medications. In the space provided, document the following:
    - The names of the medications tried
    - The approximate dates the medications were received
    - Specific details about the treatment results, including if the medications resulted in an unsatisfactory therapeutic response(s) or a clinically significant adverse drug reaction(s)

1. ❑ Antidepressants

2. ❑ Anticonvulsants

3. ❑ Beta Blockers

4. ❑ Calcium Channel Blockers

Has the member tried migraine prophylaxis medications from **at least three** of the drug categories listed above? ❑ Yes ❑ No

Does the member have a medical condition(s) **or** is there a clinically significant drug interaction(s) with a medication the member is currently taking that prevents them from taking **two or more** of the drug categories listed above? ❑ Yes ❑ No

If yes, document the drug name(s), approximate date(s) taken, and the reason for discontinuation or a medical condition(s) and/or drug interaction(s) that prevents the member from taking a drug from **two or more** of the drug categories listed above.

Continued

SECTION V – CLINICAL INFORMATION – RENEWAL REQUESTS ONLY

21. Has the member experienced/sustained a clinically significant decrease in the number of migraine days per month compared to their baseline prior to initiation of treatment with a migraine agent, CGRP antagonist drug? ☐ Yes ☐ No

    If yes, indicate the current number of migraine days per month.

    Migraine Days Per Month _____

22. Has the prescriber confirmed the member's headaches are not due to medication overuse or attributed to another causative disorder? ☐ Yes ☐ No

23. Document the member's current migraine treatment plan, including medications and non-pharmacologic treatments (that is, behavioral therapies, physical therapies, lifestyle modifications).

24. Has the member been compliant with the above documented migraine treatment plan, including medication adherence and non-pharmacologic treatments (that is, behavioral therapies, physical therapies, lifestyle modifications)? ☐ Yes ☐ No

SECTION VI – AUTHORIZED SIGNATURE

25. **SIGNATURE –** Prescriber	26. Date Signed

SECTION VII – ADDITIONAL INFORMATION

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

Reset Form