FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR MIGRAINE AGENTS, CALCITONIN GENE-RELATED PEPTIDE (CGRP) ANTAGONISTS

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment 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 Drug Attachment 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 medical work-up for migraines and complete problem and medication list.

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 prescriber confirmed the member's headaches are not due to medication overuse? ❑ Yes ❑ No

17. Document the member's current headache frequency and prescribed medication treatment regimen.

Headache Days Per Month _____

Migraine Days Per Month _____ Average Migraine Duration in Hours _____

List current prescribed headache prophylaxis medications (drug name[s], **including Botox [if applicable]**; dose; and dosing frequency).

List current prescribed headache rescue medications (drug name[s], dose, and dosing frequency).

Has the member been compliant with the current prescribed headache medication treatment regimen? ❑ Yes ❑ No

Continued

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

18. 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. ❑ Angiotensin-Converting Enzyme (ACE) Inhibitors/Angiotensin Receptor Blockers (ARBs)

2. ❑ Anticonvulsants

3. ❑ Antidepressants

4. ❑ Beta Blockers

5. ❑ Calcium Channel Blockers

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

If 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 a drug in each of the drug categories listed above that has not been attempted? ❑ Yes ❑ No

If yes, document the drug category and the medical condition(s) or clinically significant drug interaction(s) that prevent the member from taking a drug in any of the categories the member has not attempted.

Drug Category _____ Condition / Interaction _____

Drug Category _____ Condition / Interaction _____

Drug Category _____ Condition / Interaction _____

Drug Category _____ Condition / Interaction _____

Continued

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

19. Document the member's proposed headache medication treatment regimen.

List the proposed headache prophylaxis medications (drug name[s], **including Botox [if applicable] and the requested CGRP antagonist**; dose; and dosing frequency).

List the proposed headache rescue medications (drug name[s], dose, and dosing frequency).

SECTION V – CLINICAL INFORMATION – RENEWAL REQUESTS ONLY

20. 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 headache days per month, the number of migraine days per month, and the average migraine duration.

Headache Days Per Month _____

Migraine Days Per Month _____ Average Migraine Duration in Hours _____

21. List the current prescribed headache prophylaxis medications (drug name[s], **including Botox [if applicable] and the requested CGRP antagonist**; dose; and dosing frequency).

List the current prescribed headache rescue medications (drug name[s], dose, and dosing frequency).

Has the member been compliant with the current prescribed headache medication treatment regimen? ☐ Yes ☐ No

Continued

SECTION VI – AUTHORIZED SIGNATURE

22. **SIGNATURE –** Prescriber	23. Date Signed

SECTION VII – ADDITIONAL INFORMATION

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

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