**FORWARDHEALTH**

# PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEADACHE AGENTS, ACUTE TREATMENT

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Headache Agents, Acute Treatment Instructions, F-02666A. Providers may refer to the Forms page of the ForwardHealth Portal at https://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 Drug Attachment for Headache Agents, Acute Treatment 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

13. Diagnosis Code and Description

**Note: A copy of the member's medical records must be submitted with all PA requests for headache agents, acute treatment drugs. Medical records must document the member's medical work-up for migraines, including complete problem and medication lists.**

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 International Classification of Headache Disorders, 3rd edition, diagnostic criteria? ❑ Yes ❑ No

16. Has the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with **at least two** preferred drugs from the headache agents, triptans non-injectable drug class? ❑ Yes ❑ No

If yes, list the drug name and date(s) the drug was taken in the space provided for **each** of the **two** preferred drugs the member has taken from the headache agents, triptans non-injectable drug class.

Drug Name _____ Date(s) Taken _____

Drug Name _____ Date(s) Taken _____

Drug Name _____ Date(s) Taken _____

Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s).

17. Does the member have a medical condition(s) that prevents the use of triptans? ❑ Yes ❑ No

If yes, list the medical condition(s) and describe how the condition(s) prevents the member from using triptans.

**SECTION IV – AUTHORIZED SIGNATURE**

| 18. **SIGNATURE** – Prescriber | 19. Date Signed |
|---|---|
| | |

**SECTION V – ADDITIONAL INFORMATION**

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

Reset Form