DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02666 (07/2021)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

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. Prescribers 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 and dated by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Prescribers and pharmacy 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. Address – Prescriber (Street, City, State, Zip+4 Code)

11. Phone Number – Prescriber	12. National Provider Identifier – Prescriber

SECTION III – CLINICAL INFORMATION (Required for all PA requests)

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 demonstrate the member meets the clinical criteria and 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 migraines, 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 dates 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 _____ Dates Taken _____

Drug Name _____ Dates Taken _____

Drug Name _____ Dates 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 – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED HEADACHE AGENTS, ACUTE TREATMENT DRUG REQUESTS

18. Has the member experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction with a preferred headache agents, acute treatment drug? ❑ Yes ❑ No

If yes, list the drug and dose, specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction, and the approximate dates the drug was taken.

19. Does the member have a medical condition(s) preventing the use of a preferred headache agents, acute treatment drug? ❑ Yes ❑ No

If yes, list the medical condition(s) that prevents the use of a preferred headache agents, acute treatment drug.

20. Is there a clinically significant drug interaction between another medication the member is taking and a preferred headache agents, acute treatment drug? ❑ Yes ❑ No

If yes, list the medication(s) and interaction(s).

SECTION V – AUTHORIZED SIGNATURE

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

SECTION VI – ADDITIONAL INFORMATION

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

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