DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02666 (07/2022)

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 Requests)

13. Diagnosis Code and Description

Note: Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for non-preferred 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. 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, third edition, diagnostic criteria? ❑ Yes ❑ No

15. 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 responses or clinically significant adverse drug reactions.

16. Is there a clinically significant drug interaction between another drug the member is taking and triptans, or does the member have a medical condition(s) that prevents the use of triptans? ❑ Yes ❑ No

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

17. Indicate the preferred headache agents, acute treatment drugs the member has taken and provide specific details regarding the member's response to treatment and the reason(s) for discontinuing. If additional space is needed, continue documentation in Section V of this form.

1. Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuing

2. Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuing

3. Drug Name _____ Dose _____ Dates Taken _____

Description of Treatment Response and Reason(s) for Discontinuing

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