DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02667 (07/2020)

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

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEADACHE AGENTS, PREVENTATIVE TREATMENT

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Headache Agents, Preventative Treatment Instructions, F-02667A. Providers may refer to the Forms page of the ForwardHealth Portal at 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, Preventative 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 – ALL 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, preventative treatment drugs. Medical records must document the member's medical work-up for migraines, including complete problem and medication lists.

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, diagnostic criteria? ❑ Yes ❑ No

16. Document the member's current migraine prescribed medication treatment regimen.

List the current prescribed migraine preventative medications (drug name[s], dose, and dosing frequency), **including Botox (if applicable)**.

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

17. Has the member taken Ajovy for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction? ❑ Yes ❑ No

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

18. Has the member taken Emgality 120 mg for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction? ❑ Yes ❑ No

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

SECTION V – CLINICAL INFORMATION – RENEWAL REQUESTS ONLY

19. Has the member experienced/sustained a clinically significant decrease in the number of migraine days per month and/or a decrease in migraine duration compared to their baseline prior to initiation of treatment with a headache agent, preventative treatment drug? ☐ Yes ☐ No

20. List the current prescribed migraine preventative medications (drug name[s], dose, and dosing frequency), **including Botox (if applicable)**.

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

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

SECTION VI – AUTHORIZED SIGNATURE

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

SECTION VII – 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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