DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-02667 (07/2021)

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. Prescribers 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 and dated by the prescriber before submitting a prior authorization 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 – ALL REQUESTS

13. Diagnosis Code and Description

Note: A copy of the member's medical records must be submitted with all prior authorization requests for non-preferred headache agents, preventative treatment drugs. Medical records must demonstrate that the member meets the clinical criteria and document the member's medical work-up for migraines, including the current number of headache days per month, the number of migraine days per month, the average migraine duration (in hours), as well as 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 migraines, with or without aura, according to the International Classification of Headache Disorders, 3rd edition, diagnostic criteria? ❑ Yes ❑ No

16. Document the member's current headache frequency.

    Headache Days Per Month _____ Migraine Days Per Month _____

    Average Migraine Duration in Hours _____

17. 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).

18. 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.

19. 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

20. 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

21. Document the member's current headache frequency.

Headache Days Per Month _____ Migraine Days Per Month _____

Average Migraine Duration in Hours _____

22. 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

23. **SIGNATURE** – Prescriber	24. Date Signed

SECTION VII – ADDITIONAL INFORMATION

25. 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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