**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-02667 (07/2022)

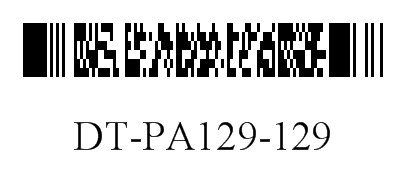
**FORWARDHEALTH**

**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](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, Preventative 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.

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| **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: 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, 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.** | |



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| **SECTION IV – CLINICAL INFORMATION – INITIAL REQUESTS ONLY** |
| 14. 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,  third edition, diagnostic criteria?  Yes  No |
| 15. Document the member’s current headache frequency.  Headache Days Per Month       Migraine Days Per Month  Average Migraine Duration in Hours |
| 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. Indicate the preferred headache agents, preventative 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 VII 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 |

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| **SECTION V – CLINICAL INFORMATION – RENEWAL REQUESTS ONLY** | |
| 18. 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 | |
| 19. Document the member’s current headache frequency.  Headache Days Per Month       Migraine Days Per Month  Average Migraine Duration in Hours | |
| 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. | |