UnitedHealthcare Community Plan

Migraine Prevention Agents - Pennsylvania
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Episodic cluster headache □ Migraine with or without aura
□ **Yes** □ **No**	**Was the diagnosis confirmed according to the current International Headache Society Classification of Headache Disorders?**
□ **Yes** □ **No**	**Is the requested medication prescribed by or in consultation with one of the following?** *(If yes, check which applies)* □ Neurologist □ Headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)
□ **Yes** □ **No**	**Does the patient have a contraindication to the prescribed medication?**
□ **Yes** □ **No**	**Is the patient currently using a migraine prevention agent?**
□ **Yes** □ **No** □ **Not applicable**	**If yes to the above question, do any of the following apply?** *(If yes, check which applies)* □ Patient will discontinue use of that migraine prevention agent prior to starting the requested migraine prevention agent □ Patient has a medical reason for concomitant use of both migraine prevention agents that is supported by peer-reviewed literature or national treatment guidelines
□ **Yes** □ **No**	**If the request is for a non-preferred medication, does the patient have a history of therapeutic failure, contraindication, or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the patient's diagnosis or indication?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
QULIPTA	
□ **Yes** □ **No**	**Is the patient currently using a different "gepant" drug?**
□ **Yes** □ **No** □ **Not applicable**	**If yes to the above question, do any of the following apply?** *(If yes, check which applies)* □ Patient will discontinue use of that gepant prior to starting the requested gepant □ Patient has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines
EPISODIC CLUSTER HEADACHE	
□ **Yes** □ **No**	**Does the patient have a documented history of therapeutic failure, contraindication, or intolerance of at least ONE other preventive medication recommended by current consensus guidelines for episodic cluster headache (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, American Headache Society)?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
MIGRAINE PREVENTION	
□ **Yes** □ **No**	**Is there documentation of baseline average number of migraine days and headache days per month?**
□ **Yes** □ **No**	**Has the patient averaged four or more migraine days per month over the previous three months?**
□ **Yes** □ **No**	**Does the patient have a history of <u>therapeutic failure</u> of at least one preventive medication from any of the following three classes?** *(If yes, check which applies & complete "Previous Medication Trials/Contraindications" section on first page)* □ Beta-blockers (e.g., metoprolol, propranolol, timolol) □ Antidepressants (e.g., amitriptyline, venlafaxine) □ Anticonvulsants (e.g., topiramate, valproic acid, divalproex)
□ **Yes** □ **No**	**Does the patient have a <u>contraindication or intolerance</u> that prohibits a trial of at least one preventive medication from any of the following three classes?** *(If yes, check which applies & complete "Previous Medication Trials/Contraindications" section on first page)* □ Beta-blockers (e.g., metoprolol, propranolol, timolol) □ Antidepressants (e.g., amitriptyline, venlafaxine) □ Anticonvulsants (e.g., topiramate, valproic acid, divalproex)

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CONTINUATION OF THERAPY - EPISODIC CLUSTER HEADACHE	
□ Yes □ No	**Is there documentation of a positive clinical response as evidenced by a reduction in cluster headache frequency from baseline?**
CONTINUATION OF THERAPY - MIGRAINE PREVENTION	
□ Yes □ No	**Does the patient have a reduction in the average number of migraine days or headache days per month from baseline?**
□ Yes □ No	**Has the patient experienced a decrease in severity or duration of migraines from baseline?**

Provider Signature: _____ Date: _____