UnitedHealthcare Community Plan

# Migranal Nasal Spray
## 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.**

**Section A – Member Information**

| | | |
|---|---|---|
| First Name: | Last Name: | Member ID: |
| Address: | | |
| City: | State: | ZIP Code: |
| Phone: | DOB: | Allergies: |
| Primary Insurance Information (if any): | | |

**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: _____**

**Section B - Provider Information**

| | | | | |
|---|---|---|---|---|
| First Name: | | Last Name: | | M.D./D.O. |
| Address: | | City: | State: | ZIP code: |
| Phone: | Fax: | NPI #: | Specialty: | |
| Office Contact Name / Fax attention to: | | | | |

**Section C - Medical Information**

| | |
|---|---|
| **Medication:** | **Strength:** |
| **Directions for use:** | **Quantity:** |
| **Diagnosis** (Please be specific & provide as much information as possible)**:** | **ICD-10 CODE:** |

**Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____**

**Section D – Previous Medication Trials**

| Medication Name | Strength | Directions | Dates of Therapy | Reason for failure / discontinuation |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives**

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| Member First name: | Member Last name: | Member DOB: |
|---|---|---|

## Clinical and Drug Specific Information

**Please provided evidence to support safety and additional efficacy at higher than maximum doses as documented in published biomedical literature demonstrating safety and efficacy of doses/quantities greater than those approved by the FDA for the diagnosis indicated.**

| | |
|---|---|
| | **ALL REQUESTS** |
| □ Yes □ No | **Does the patient have a diagnosis of migraine headaches with or without aura?** |
| □ Yes □ No | **Does the patient have a history of failure, contraindication, or intolerance to two preferred 5-HT1 receptor agonist (triptan) alternatives [e.g., Imitrex (sumatriptan), Maxalt or Maxalt-MLT (rizatriptan)]?** *(If yes, complete Section D above)* |
| | **List requested quantity per month:** |
| | **QUANTITY LIMITATIONS** |
| □ Yes □ No | **Does the patient have two or more headaches monthly?** |
| □ Yes □ No | **Is Migranal prescribed by or in consultation with a neurologist or pain management specialist?** |
| □ Yes □ No | **Is the patient currently receiving prophylactic therapy with at least one of the following agents, or has a contraindication or intolerance to all of the following:** *(If yes, complete Section D above)*<br>□ Amitriptyline (Elavil)<br>□ One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol<br>□ Divalproex sodium (Depakote/Depakote ER)<br>□ Topiramate (Topamax)<br>□ Venlafaxine (Effexor/Effexor XR) |
| □ Yes □ No | **Does the physician acknowledge that the potential benefit outweighs the risk associated with the higher dose or quantity?** |

**Provider Signature:** _____ **Date:** _____