



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Migraine Prevention Agents

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this a request for a renewal of authorization?

Yes

No

Q2. Does the patient have a contraindication to the requested drug?

Yes

No

Q3. Is the requested Migraine Prevention Agent prescribed by or in consultation with a neurologist OR a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)?

Yes

No

Q4. Is the requested drug being prescribed for the prevention of migraine?

Yes

No

Q5. Has the patient had a reduction in the average number of migraine days or headache days per month from baseline?

Yes

No

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<p>Q6. Has the patient experienced a decrease in the severity or duration of migraines from baseline?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is the requested drug being prescribed for a diagnosis of episodic cluster headache?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Does the patient have documentation of a positive clinical response to the requested drug, as evidenced by a reduction in cluster headache frequency from baseline?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q9. For preferred gepant for the prevention of migraine: Has a documented history of therapeutic failure, contraindication, or intolerance to the preferred CGRP mAbs approved or medically accepted for the indication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q10. Is the patient being prescribed a dose and duration of therapy that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q11. Is the patient being treated for a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package insert OR a medically accepted indication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q12. Is the requested drug age appropriate for the patient according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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<p>Q13. Is the patient being prescribed a dose that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q14. Does the patient have a contraindication to the requested drug?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q15. Is the requested Migraine Prevention Agent prescribed by or in consultation with a neurologist OR a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q16. Is the requested drug being prescribed for the prevention of migraine?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q17. Does the patient have a diagnosis of migraine with or without aura confirmed according to the current International Headache Society Classification of Headache Disorders?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q18. Does the patient have documentation of the baseline average number of migraine days and headache days per month?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q19. Has the patient averaged four or more migraine days per month over the previous three months?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q20. Does the patient have a history of therapeutic failure of at least one preventive drug from TWO of the following three drug classes: A) beta blockers (e.g., metoprolol, propranolol, timolol), B) antidepressants (e.g., amitriptyline, venlafaxine), C) anticonvulsants (e.g., topiramate, valproic acid, divalproex)?</p>

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<p align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	
<p>Q21. Does the patient have a contraindication or intolerance that prohibits a trial of at least one preventive drugs from two of the following three drug classes: A) beta blockers (e.g., metoprolol, propranolol, timolol), B) antidepressants (e.g., amitriptyline, venlafaxine), C) anticonvulsants (e.g., topiramate, valproic acid, divalproex)?</p> <p align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	
<p>Q22. Is the requested drug being prescribed for a diagnosis of episodic cluster headache?</p> <p align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	
<p>Q23. Does the patient have a diagnosis of episodic cluster headache confirmed according to the current International Headache Society Classification of Headache Disorders?</p> <p align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	
<p>Q24. Does the patient have a documented history of therapeutic failure, contraindication , or intolerance of at least one other preventive drug 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)?</p> <p align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	
<p>Q25. If currently using a Migraine Prevention Agent for the preventive treatment of migraine or the treatment of episodic cluster headaches, one of the following: a) will discontinue use of that Migraine Prevention Agent prior to starting the requested Migraine Prevention Agent; b) has medical reason for concomitant use of both Migraine Prevention Agents that is supported by peer-reviewed literature or national treatment guidelines?</p> <p align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	
<p>Q26. For a gepant, if currently using a different gepant, one of the following: a) Will discontinue use of that gepant prior to starting the requested gepant; b) Has a medical reason for concomitant use of both gepants that is supported by peer-reviewed literature or national treatment guidelines?</p> <p align="center"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p>	



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Q27. For preferred gepant for the prevention of migraine, has a documented history of therapeutic failure, contraindication, or intolerance to the preferred CGRP monoclonal antibodies (mAbs) approved or medically accepted for the indication?

Yes

No

Q28. Is the request for a non-preferred Migraine Prevention Agent?

Yes

No

Q29. Does the patient have a documented history or therapeutic failure, contraindication, or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the patient's diagnosis or indication?

Yes

No

Q30. Additional Information:

Prescriber Signature

Date

v2026-06