HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM

ACUTE MIGRAINE

D.H.E 45®, Migranal®, Nurtec™, Reyvow™, Treximet®, Ubrelvy™

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ dihydroergotamine mesylate injection, ☐ dihydroergotamine mesylate nasal spray, ☐ Nurtec™ (rimegepant) ODT, ☐ Reyvow™ (lasmmiditan), ☐ Treximet® (sumatriptan and naproxen sodium), ☐ Ubrelvy™ (ubrogepant)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, a neurologist or headache specialist?	☐	☐	
2. Does the member have a documented diagnosis of migraine with or without aura?	☐	☐	**Please provide documentation**
3. Has possible rebound headaches from medication use and/or medication overuse been ruled out?	☐	☐	**Please provide documentation**
4. Is the migraine moderate to severe causing functional impairment such as missed days of school/work, decreased ability to perform daily activities, etc.?	☐	☐	**Please provide documentation**
5. Does the member have less than 15 headache days per month?	☐	☐	**Please provide documentation**
6. Has the member had a trial and failure of at least 2 preferred generic triptan medications (e.g. almotriptan, eletriptan, frovatriptan, naratriptan, sumatriptan, rizatriptan, zolitriptan) at maximum tolerated FDA dose, or contraindication or intolerance to all preferred generic triptan medications?	☐	☐	**Please provide documentation**
7. Has the member tried both an oral and either nasal OR subcutaneaous triptan?	☐	☐	**Please provide documentation**
DIHYDROERGOTAMINE MESYLATE NASAL SPRAY			
1. Has the member had a trial and failure, or intolerance, to dihydroergotamine injection?	☐	☐	**Please provide documentation**

TREXIMET			
1. Has the member tried and found to be intolerant to the inactive ingredients in both naproxen sodium and sumatriptan?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated in the past 12 months?			
3. Does documentation show the member has a positive clinical response to therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 088
Origination Date: 05/12/2020
Reviewed/Revised Date: 01/27/2021
Next Review Date: 01/27/2022
Current Effective Date: 02/01/2021