

MIGRAINE ACUTE TREATMENT AGENTS PRIOR AUTHORIZATION FORM

(form effective 1/5/2026)



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pages:	
Name of office contact:		Contact's phone number:	LTC facility contact/phone:
PATIENT INFORMATION			
Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:		Phone:
PRESCRIBER INFORMATION			
Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	
CLINICAL INFORMATION			
Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.			
Preferred:		Non-Preferred:	
<input type="checkbox"/> Eletriptan Tablet <input type="checkbox"/> Naratriptan Tablet <input type="checkbox"/> Nurtec (rimegepant) ODT <input type="checkbox"/> Rizatriptan ODT <input type="checkbox"/> Rizatriptan Tablet <input type="checkbox"/> Sumatriptan Cartridge <input type="checkbox"/> Sumatriptan Nasal Spray		<input type="checkbox"/> Sumatriptan Pen Injector <input type="checkbox"/> Sumatriptan Tablet <input type="checkbox"/> Sumatriptan Vial <input type="checkbox"/> Ubrelvy Tablet <input type="checkbox"/> Zolmitriptan ODT <input type="checkbox"/> Zolmitriptan Tablet <input type="checkbox"/> Almotriptan Tablet <input type="checkbox"/> Diclofenac Potassium Powder Packet <input type="checkbox"/> Dihydroergotamine Mesylate Ampule <input type="checkbox"/> Dihydroergotamine Mesylate Nasal Spray <input type="checkbox"/> Elyxib Solution <input type="checkbox"/> Ergomar SL Tablet <input type="checkbox"/> Frova Tablet <input type="checkbox"/> Frovatriptan Tablet <input type="checkbox"/> Imitrex Cartridge <input type="checkbox"/> Imitrex Pen Injector <input type="checkbox"/> Imitrex Tablet <input type="checkbox"/> Maxalt Tablet <input type="checkbox"/> Maxalt MLT	
<input type="checkbox"/> Relpax Tablet <input type="checkbox"/> Reyvow Tablet <input type="checkbox"/> Sumatriptan-Naproxen Tablet <input type="checkbox"/> Symbravo Tablet <input type="checkbox"/> Tosymra Nasal Spray <input type="checkbox"/> Trudhesa Nasal Spray <input type="checkbox"/> Zavzpret Nasal Spray <input type="checkbox"/> Zembrace Symtouch <input type="checkbox"/> Zolmitriptan Nasal Spray <input type="checkbox"/> Zomig Nasal Spray <input type="checkbox"/> Zomig Tablet			
Strength and dosage form:			
Dose/directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):			Dx code (<i>required</i>):

INITIAL REQUESTS
<p>Please complete either the INITIAL requests or RENEWAL requests section.</p> <p>If the requested prescription exceeds the quantity limits/daily dose limits, also complete the QUANTITY LIMITS/DAILY DOSE LIMITS section.</p>
<p>1. For a NON-PREFERRED MIGRAINE ACUTE TREATMENT AGENT</p> <p><input type="checkbox"/> For a non-preferred TRIPTAN:</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.)</p> <p><input type="checkbox"/> List medications tried: _____</p> <p><input type="checkbox"/> For a non-preferred GEPANT:</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to the preferred GEPANTS (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred gepants in the Migraine Acute Treatment Agents class.)</p> <p><input type="checkbox"/> List medications tried: _____</p> <p><input type="checkbox"/> For a non-preferred non-steroidal anti-inflammatory drug (NSAID):</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to the preferred oral NSAIDS (excluding ketorolac) that are approved or medically accepted for the treatment of the beneficiary's diagnosis (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred oral NSAIDS in the statewide PDL class.)</p> <p><input type="checkbox"/> List medications tried: _____</p>

INITIAL REQUESTS

- For **ALL OTHER non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, etc.):**
 - Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class that are approved or medically accepted for the treatment of the beneficiary's diagnosis (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
- For a **GEPANT/SMALL MOLECULE CGRP INHIBITOR (e.g., Nurtec ODT, Ubrovvy)**
 - Tried and failed at least 2 triptans (e.g., rizatriptan, sumatriptan, etc.) or has a contraindication or intolerance to triptans
- For a **non-preferred TRIPTAN-NSAID combination product:**
 - Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
 - Has a clinical reason why the individual active ingredients cannot be used concurrently
 - For Symbravo (meloxicam-rizatriptan):
 - Tried and failed or has a contraindication or an intolerance to sumatriptan-naproxen

- For a **DITAN/5HT1 RECEPTOR AGONIST (e.g., Reyvow)**
 - Tried and failed or has a contraindication or intolerance to the preferred triptans (refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class)
 - List medications tried: _____
- For an **ERGOT ALKALOID (e.g., Cafergot, D.H.E., Migranal, etc.)**
 - Tried and failed or has a contraindication or intolerance to the following:
 - caffeine/analgesic combination (e.g., Excedrin)
 - NSAIDs
 - triptans
 - a combination of an NSAID with a triptan
 - other: _____

RENEWAL REQUESTS

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

- Experienced improvement in headache pain, symptoms, or duration
- For a **NON-PREFERRED MIGRAINE ACUTE TREATMENT AGENT**
 - For a **non-preferred TRIPTAN:**
 - Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
 - For a **non-preferred GEPANT:**
 - Tried and failed or has a contraindication or an intolerance to the preferred GEPANTS (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred gepants in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
 - For a **non-preferred non-steroidal anti-inflammatory drug (NSAID):**
 - Tried and failed or has a contraindication or an intolerance to the preferred oral NSAIDS (excluding ketorolac) that are approved or medically accepted for the treatment of the beneficiary's diagnosis (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred oral NSAIDS in the statewide PDL class.)
 - List medications tried: _____
 - For **ALL OTHER non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, etc.):**
 - Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class that are approved or medically accepted for the treatment of the beneficiary's diagnosis (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
 - For a **non-preferred TRIPTAN-NSAID combination product:**
 - Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
 - Has a clinical reason why the individual active ingredients cannot be used concurrently
 - For Symbravo (meloxicam-rizatriptan):
 - Tried and failed or has a contraindication or an intolerance to sumatriptan-naproxen

QUANTITY LIMITS/DAILY DOSE LIMITS REQUESTS

All requests that exceed the quantity limits/daily dose limits require prior authorization.

Is the requested medication prescribed by a neurologist or specialist certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)? Yes No

Is the requested quantity/dose/frequency supported by current medical compendia and/or peer-reviewed medical literature? Yes No Submit documentation.

1. For ACUTE TREATMENT OF MIGRAINE, check all that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each:

- Was evaluated for the overuse of abortive headache medications (e.g., opioids, triptans, butalbital, etc.)
- Will be using the requested medication with at least one medication for migraine prevention – specify:
 - anticonvulsant (e.g., topiramate, valproate derivative)
 - antidepressant (e.g., SNRI, TCA)
 - beta blocker (e.g., metoprolol, propranolol, timolol)
 - botulinum toxin (e.g., Botox, Dysport)
 - CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
 - gepant (e.g., Nurtec ODT, Qulipta)
 - other: _____
- Tried and failed preventive migraine medications – specify:
 - anticonvulsant (e.g., topiramate, valproate derivative)
 - antidepressant (e.g., SNRI, TCA)
 - beta blocker (e.g., metoprolol, propranolol, timolol)
 - botulinum toxin (e.g., Botox, Dysport)
 - CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
 - gepant (e.g., Nurtec ODT, Qulipta)
 - other: _____
- Has an intolerance or a contraindication to preventive migraine medications – specify:
 - anticonvulsant (e.g., topiramate, valproate derivative)
 - antidepressant (e.g., SNRI, TCA)
 - beta blocker (e.g., metoprolol, propranolol, timolol)
 - botulinum toxin (e.g., Botox, Dysport)
 - CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
 - gepant (e.g., Nurtec ODT, Qulipta)
 - other: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature: _____

Date: _____

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking of any telecopy is strictly prohibited.