Prophylactic CGRP Receptor Antagonist Prior Authorization Form

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) (First) (MI)	WV Medicaid 11-Digit ID #	Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) (First) (Credentials)	(Specialty)

Prescriber Address (Street) (City) (State) (Zip)

Prescriber 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) (City) (State) (Zip)

Pharmacy 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)

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Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name	Strength	Route of Administration

Directions	Diagnosis	ICD-10 Diagnosis Code (if available)

Has the patient experienced treatment failure with a **beta blocker** for this condition? If yes, provide trial details for each previously attempted beta blocker. Attach additional pages if necessary. If no, further comment is optional. ☐ Yes ☐ No

Beta Blocker Drug Name #1	Strength	Directions	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)

Reason for Discontinuing

Beta Blocker Drug Name #2	Strength	Directions	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)

Reason for Discontinuing

Has the patient experienced treatment failure with an **antidepressant** for this condition? If yes, provide trial details for each previously attempted antidepressant. Attach additional pages if necessary. If no, further comment is optional. ☐ Yes ☐ No

Antidepressant Drug Name #1	Strength	Directions	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)

Reason for Discontinuing

Antidepressant Drug Name #2	Strength	Directions	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)

Reason for Discontinuing

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Has the patient experienced treatment failure with an **anticonvulsant** for this condition? If yes, provide trial details for each previously attempted antidepressant. Attach additional pages if necessary. If no, further comment is optional.				☐ Yes ☐ No
Anticonvulsant Drug Name #1	Strength	Directions	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Discontinuing				
Anticonvulsant Drug Name #2	Strength	Directions	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Reason for Discontinuing				

Does the patient have a contraindication to attempting therapy with a beta blocker, antidepressant, and/or anticonvulsant? If yes, list and explain. If no, further comment is optional.	☐ Yes ☐ No

Migraine Frequency (days per month requiring acute pharmacologic treatment)	Date Assessed (MM/DD/YYYY)

Please provide at least one of the following objective assessments of migraine disability/impact.

Migraine Disability Assessment (MIDAS)	Score	Date Assessed (MM/DD/YYYY)
Headache Impact Test-6 (HIT-6)	Score	Date Assessed (MM/DD/YYYY)

Other pertinent information:

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.	☐ Check here for electronic signature
Prescriber or Pharmacist Signature:	Date: (MM/DD/YYYY)