GHP Family Pharmacy Customer Service
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GeisingerHealthPlan.com

Geisinger
GHP Family

ANTIMIGRAINE AGENTS, OTHER – ACUTE TREATMENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antimigraine Agents, Other** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plans website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength & dosage form:
To request a CGRP inhibitor (e.g., Aimovig, Ajovy, Emgality, etc), please use the Antimigraine, Other – CGRP Inhibitors form.	
Dose/directions:	Quantity: / Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):
Does the beneficiary have any of the following contraindications to the requested medication, including but not limited to the following? *Check all that apply.* ☐currently pregnant or breastfeeding ☐hypertension ☐liver impairment ☐kidney impairment ☐sepsis ☐heart disease (such as peripheral vascular disease, coronary artery disease, ischemic heart disease, and history of MI) ☐cerebrovascular insufficiency	☐Yes ☐No *Submit documentation.*
Is the beneficiary currently taking any medications that are contraindicated with the requested medication (e.g., strong CYP3A4 inhibitors [e.g., protease inhibitors, azole antifungals, some macrolide antibiotics], peripheral or central vasoconstrictors, MAO inhibitors)?	☐Yes ☐No *Submit beneficiary's complete current medication list.*
INITIAL Requests	
Does the beneficiary have a diagnosis of headache that is consistent with current International Classification of Headache Disorders (ICHD) criteria?	☐Yes ☐No *Submit documentation of diagnosis.*
Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? *Check all that apply.* ☐caffeine/analgesic combination (e.g., Excedrin) ☐NSAIDs ☐triptans ☐a combination of an NSAID with a triptan	☐Yes ☐No *Submit documentation.*
RENEWAL Requests	
Has the beneficiary experienced an improvement in headache pain control or duration since starting the requested medication?	☐Yes ☐No *Submit documentation.*

Please submit to PromptPA **https://ghp.promptpa.com** OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date: