GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

MIGRAINE PREVENTION AGENTS PRIOR AUTHORIZATION FORM *(form effective 01/03/2022)*

Prior authorization guidelines for **Migraine Prevention Agents** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	# 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:	Formulation (pen, syringe, tablet, etc):	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
Is the medication being prescribed by or in consultation with a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties or a neurologist?		☐Yes ☐No	*Submit documentation of consultation, if applicable.*

INITIAL requests

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

☐**For PREVENTION OF MIGRAINE:**
- ☐Averaged 4 or more migraine days per month over the past 3 months
- ☐Tried and failed (or cannot try) other preventive migraine medications
  - ☐Anticonvulsants (e.g., divalproex, topiramate, valproic acid)
  - ☐Antidepressants (e.g., amitriptyline, venlafaxine)
  - ☐Beta blockers (e.g., metoprolol, propranolol, timolol)

☐**For EPISODIC CLUSTER HEADACHE:**
- ☐Tried and failed (or cannot try) at least one other preventive medication

☐**For NURTEC ODT (rimegepant) for PREVENTION OF MIGRAINE:**
- ☐Tried and failed (or cannot try) the preferred CGRP monoclonal antibodies approved or medically accepted for the diagnosis (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents)*

☐**For a NON-PREFERRED Migraine Prevention Agent:**
- ☐Tried and failed or has a contraindication or intolerance to the preferred Migraine Prevention Agents approved or medically accepted for the diagnosis (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Migraine Prevention Agents)*

RENEWAL requests

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

☐**For PREVENTION OF MIGRAINE:**
- ☐Experienced fewer average migraine days or headache days per month since starting the requested medication
- ☐Experienced a decrease in severity or duration of migraines since starting the requested medication

☐**For EPISODIC CLUSTER HEADACHE:**
- ☐Experienced a reduction in the frequency of episodic cluster headache since starting the requested medication

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.

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Prescriber Signature:	**Date**:

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