Migraine Prophylaxis/Treatment Prior Authorization Form

Fax completed form to: 855-207-0250
For questions regarding this prior authorization, call 866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that members receiving a prescription for migraine treatment/prophylaxis must meet the following criteria:

Treatment Initial Requests: Member must have had 30-day trials of two triptans (5HT-1 agonists) within the past 2 years

Prophylaxis Initial Requests:

- Member must experience 3 or more migraine days per month.
- Member must have had 2-month trials of two preferred agents from different therapeutic classes. Documentation must include clinical notes regarding failure to reduce migraine frequency.

Prophylaxis Renewal Requests: Member must experience a reduction in migraines of at least 50%

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating prescriber)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
How will the requested product be used? ☐ Treatment ☐ Prophylaxis • **If for prophylaxis, number of experienced migraine days per month: _____**			
List all failed medications:	**Start Date:**	**End Date:**	
Additional Qualifications for Coverage (e.g. medical justification explaining inability to meet required trials)			
☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the member.*			
Prescriber (or Staff) / Pharmacy Signature**	Date		
**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*			

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #