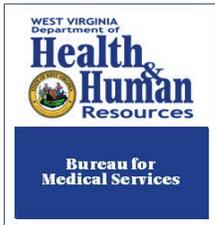


Injectable CGRP Receptor Antagonist Prior Authorization Form



West Virginia Medicaid
 Drug Prior Authorization Form
http://www.wvdhhr.org/bms/sPharmacy/Drugs/bms_drugs_main.asp

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)	(MI)	(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)		
<p>Confidentiality Notice: This document contains confidential health information that is protected by law. This information is intended only for the use of the individual or entity named above. The intended recipient of this information should destroy the information after the purpose of its transmission has been accomplished or is responsible for protecting the information from any further disclosure. The intended recipient is prohibited from disclosing this information to any other party unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately by telephone at (800) 847-3859 and arrange for the return or destruction of these documents. Thank you.</p>					
<p>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.</p>					
Drug Name		Strength		Route of Administration	
Directions		Diagnosis		ICD-10 Diagnosis Code (if available)	
<p>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. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
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					
<p>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. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No				
How many migraine days per month requiring acute pharmacologic management is the patient currently experiencing?				
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.				<input type="checkbox"/> Check here for electronic signature
Prescriber or Pharmacist Signature:				Date: (MM/DD/YYYY)