Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Headache Therapy (Serotonin Receptor Agents) Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name ____________________ First name ____________________ MI ________

MassHealth member ID # ____________________ Date of birth ____________________

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

- ☐ almotriptan
- ☐ eletriptan
- ☐ frovatriptan
- ☐ naratriptan
- ☐ Onzetra (sumatriptan nasal powder)
- ☐ Reyvow (lasmiditan)
- ☐ rizatriptan orally disintegrating tablet > quantity limits
- ☐ rizatriptan tablet > quantity limits
- ☐ sumatriptan injection
- ☐ sumatriptan 5 mg, 20 mg nasal spray
- ☐ sumatriptan tablet > quantity limits
- ☐ sumatriptan/naproxen
- ☐ Tosymra (sumatriptan 10 mg nasal spray)
- ☐ Zembrace (sumatriptan injection)
- ☐ zolmitriptan nasal spray
- ☐ zolmitriptan orally disintegrating tablet
- ☐ zolmitriptan tablet > quantity limits
- ☐ Other* ____

**If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

Quantity requested per month ____

Dose, frequency, and duration of requested drug ____

Indication (Check all that apply.)

- ☐ Cluster headache. Frequency of headaches (number/month) ____________________
- ☐ Migraine headache. Frequency of migraine attacks (number/month) ____________________
- ☐ Other. Specify pertinent medical history, diagnostic studies, and/or laboratory tests. ____________________

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Section I. Please complete for all requests, excluding generic rizatriptan orally disintegrating tablet, rizatriptan tablets, sumatriptan tablets and zolmitriptan tablets. Please note, this section must be completed for brand name Imitrex tablet, Maxalt MLT, Maxalt tablet, or Zomig tablet requests.

1. Has the member tried sumatriptan tablets?
   - ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response
     Briefly describe the details of adverse reaction or inadequate response.
     ____
   - ☐ No. Explain why sumatriptan tablets are not appropriate for this member.
     ____
2. Has the member tried rizatriptan?
   - ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response
     Briefly describe the details of adverse reaction or inadequate response.
     ____
   - ☐ No. Explain why rizatriptan is not appropriate for this member.
     ____
3. Has the member tried zolmitriptan tablets?
   - ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response
     Briefly describe the details of adverse reaction or inadequate response.
     ____
   - ☐ No. Explain why zolmitriptan tablets are not appropriate for this member.
     ____

Section II. Please complete for all requests for quantities above quantity limits.

1. Is the member under the care of a neurologist? ☐ Yes ☐ No
2. Is the member currently receiving prophylaxis?
   - ☐ Yes. Please specify.
     Drug ______________ Dose and frequency ______________
     Drug ______________ Dose and frequency ______________
   - ☐ No. Explain why prophylaxis is not appropriate for this member.
     ____

Section III. Please complete for requests for Onzetra, sumatriptan injection, sumatriptan 5 mg, 20 mg nasal spray, Tosymra, Zembrace, zolmitriptan nasal spray and zolmitriptan orally disintegrating tablets.

1. Please describe medical necessity for the use of the requested dosage formulation over tablet formulation.
   ____
2. For Tosymra requests, has the member had a trial with zolmitriptan or sumatriptan 5 mg, 20 mg nasal spray?
   - ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response
     Briefly describe the details of adverse reaction or inadequate response.
     ____
   - ☐ No. Explain why zolmitriptan or sumatriptan 5 mg, 20 mg nasal spray is not appropriate for this member.
     ____
3. For Zembrace requests, has the member had a trial with sumatriptan injection?
   - ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response
     Briefly describe the details of adverse reaction or inadequate response.
     ____

over

☐ No. Explain why sumatriptan injection is not appropriate for this member.

____

Section IV. Please complete for requests for sumatriptan/naproxen.

Please describe clinical rationale for the use of the fixed-dose combination (sumatriptan/naproxen) over the individual components.

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Section V. Please complete for requests for Reyvow.

1. Is the member under the care of a neurologist? ☐ Yes ☐ No
2. Has the member had a trial with two different triptan agents?

   ☐ Yes. Please describe the drug names and outcomes.

   Drug name ____________________ ☐ Adverse reaction ☐ Inadequate response

   Briefly describe the details of adverse reaction or inadequate response.

   ____

   Drug name ____________________ ☐ Adverse reaction ☐ Inadequate response

   Briefly describe the details of adverse reaction or inadequate response.

   ____

   ☐ No. Explain why triptan agents are not appropriate for this member.

   ____

Section VI. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

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Prescriber information

Last name* ____________________ First name* ____________________ MI ________

NPI* ____________________ Individual MH Provider ID ____________________

DEA No. ____________________ Office Contact Name ____________________

Address ____________________ City ____________ State ________ Zip ________

E-mail address ____

Telephone No.* ____________________ Fax No.* ____________________

** Required*

Prescribing provider’s attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider’s signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required ____

Printed name of prescribing provider ____________________ Date ____________________