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

Print Clear

Headache Therapy (Ergot Alkaloids and 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

Ergot Alkaloids

☐ dihydroergotamine injection
☐ dihydroergotamine nasal spray
☐ ergotamine/caffeine suppository
☐ ergotamine/caffeine tablet
☐ Trudhesa (dihydroergotamine nasal spray)

Serotonin Receptor Agents

☐ 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. _____

Section I. Please complete for all serotonin receptor agent 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 ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.
   _____
   ☐ 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 ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.
   _____
   ☐ 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 ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.
   _____
   ☐ 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 ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.
   _____
   ☐ 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 ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.
   _____

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☐ 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.

_____

_____

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 dihydroergotamine nasal spray and Trudhesa requests.

1. Has the member tried intranasal sumatriptan?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Explain why intranasal sumatriptan is not appropriate in this member.
   _____
2. Has the member tried intranasal zolmitriptan?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Explain why intranasal zolmitriptan is not appropriate in this member.
   _____

Section VII. Please complete for ergotamine/caffeine tablet requests.

1. Has the member tried sumatriptan tablets?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Explain why sumatriptan tablets are not appropriate in this member.
   _____
2. Has the member tried rizatriptan?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.
   _____
   ☐ No. Explain why rizatriptan is not appropriate in this member.
   _____

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Section VIII. Please complete for dihydroergotamine injection and ergotamine/caffeine suppository requests.

1. Please describe clinical rationale for the use of the requested dosage formulation.

   _____

2. For dihydroergotamine injection requests, has the member tried sumatriptan injection?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   _____

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

   _____

3. For ergotamine/caffeine suppository requests, has the member tried intranasal sumatriptan?
   ☐ Yes. Please describe the outcome. ☐ Adverse reaction ☐ Inadequate response ☐ Other
   Briefly describe the details of adverse reaction, inadequate response, or other.

   _____

   ☐ No. Explain why intranasal sumatriptan is not appropriate in this member.

   _____

Section IX. 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.

_____

_____

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 _____