

**MIGRAINE ACUTE
TREATMENT AGENTS
PRIOR AUTHORIZATION FORM**
(form effective 1/5/2026)



Keystone First

PERFORMRxSM
Next Generation Pharmacy Benefits

Fax to PerformRxSM at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pages:	
Name of office contact:		Contact's phone number:	LTC facility contact/phone:
PATIENT INFORMATION			
Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:		Phone:
PRESCRIBER INFORMATION			
Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	
CLINICAL INFORMATION			
Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.			
Preferred:		Non-Preferred:	
<input type="checkbox"/> Eletriptan Tablet <input type="checkbox"/> Naratriptan Tablet <input type="checkbox"/> Nurtec (rimegepant) ODT <input type="checkbox"/> Rizatriptan ODT <input type="checkbox"/> Rizatriptan Tablet <input type="checkbox"/> Sumatriptan Cartridge <input type="checkbox"/> Sumatriptan Nasal Spray		<input type="checkbox"/> Sumatriptan Pen Injector <input type="checkbox"/> Sumatriptan Tablet <input type="checkbox"/> Sumatriptan Vial <input type="checkbox"/> Ubrelvy Tablet <input type="checkbox"/> Zolmitriptan ODT <input type="checkbox"/> Zolmitriptan Tablet <input type="checkbox"/> Almotriptan Tablet <input type="checkbox"/> Diclofenac Potassium Powder Packet <input type="checkbox"/> Dihydroergotamine Mesylate Ampule <input type="checkbox"/> Dihydroergotamine Mesylate Nasal Spray <input type="checkbox"/> Elyxib Solution <input type="checkbox"/> Ergomar SL Tablet <input type="checkbox"/> Frova Tablet <input type="checkbox"/> Frovatriptan Tablet <input type="checkbox"/> Imitrex Cartridge <input type="checkbox"/> Imitrex Pen Injector <input type="checkbox"/> Imitrex Tablet <input type="checkbox"/> Maxalt Tablet <input type="checkbox"/> Maxalt MLT	
<input type="checkbox"/> Relpax Tablet <input type="checkbox"/> Reyvow Tablet <input type="checkbox"/> Sumatriptan-Naproxen Tablet <input type="checkbox"/> Symbravo Tablet <input type="checkbox"/> Tosymra Nasal Spray <input type="checkbox"/> Trudhesa Nasal Spray <input type="checkbox"/> Zavzpret Nasal Spray <input type="checkbox"/> Zembrace Symtouch <input type="checkbox"/> Zolmitriptan Nasal Spray <input type="checkbox"/> Zomig Nasal Spray <input type="checkbox"/> Zomig Tablet			
Strength and dosage form:			
Dose/directions:		Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):			Dx code (<i>required</i>):

INITIAL REQUESTS
<p>Please complete either the INITIAL requests or RENEWAL requests section.</p> <p>If the requested prescription exceeds the quantity limits/daily dose limits, also complete the QUANTITY LIMITS/DAILY DOSE LIMITS section.</p>
<p>1. For a NON-PREFERRED MIGRAINE ACUTE TREATMENT AGENT</p> <p><input type="checkbox"/> For a non-preferred TRIPTAN:</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.)</p> <p><input type="checkbox"/> List medications tried: _____</p> <p><input type="checkbox"/> For a non-preferred GEPANT:</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to the preferred GEPANTS (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred gepants in the Migraine Acute Treatment Agents class.)</p> <p><input type="checkbox"/> List medications tried: _____</p> <p><input type="checkbox"/> For a non-preferred non-steroidal anti-inflammatory drug (NSAID):</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to the preferred oral NSAIDS (excluding ketorolac) that are approved or medically accepted for the treatment of the beneficiary's diagnosis (Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred oral NSAIDS in the statewide PDL class.)</p> <p><input type="checkbox"/> List medications tried: _____</p>

INITIAL REQUESTS

- For **ALL OTHER non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, etc.):**
 - Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class that are approved or medically accepted for the treatment of the beneficiary's diagnosis (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
- For a **GEPANT/SMALL MOLECULE CGRP INHIBITOR (e.g., Nurtec ODT, Ubrovelvy)**
 - Tried and failed at least 2 triptans (e.g., rizatriptan, sumatriptan, etc.) or has a contraindication or intolerance to triptans
- For a **non-preferred TRIPTAN-NSAID combination product:**
 - Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
 - Has a clinical reason why the individual active ingredients cannot be used concurrently
 - For Symbravo (meloxicam-rizatriptan):
 - Tried and failed or has a contraindication or an intolerance to sumatriptan-naproxen

- For a **DITAN/5HT1 RECEPTOR AGONIST (e.g., Reyvow)**
 - Tried and failed or has a contraindication or intolerance to the preferred triptans (refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class)
 - List medications tried: _____
- For an **ERGOT ALKALOID (e.g., Cafergot, D.H.E., Migranal, etc.)**
 - Tried and failed or has a contraindication or intolerance to the following:
 - caffeine/analgesic combination (e.g., Excedrin)
 - NSAIDs
 - triptans
 - a combination of an NSAID with a triptan
 - other: _____

RENEWAL REQUESTS

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

- Experienced improvement in headache pain, symptoms, or duration
- For a **NON-PREFERRED MIGRAINE ACUTE TREATMENT AGENT**
 - For a **non-preferred TRIPTAN:**
 - Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
 - For a **non-preferred GEPANT:**
 - Tried and failed or has a contraindication or an intolerance to the preferred GEPANTS (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred gepants in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
 - For a **non-preferred non-steroidal anti-inflammatory drug (NSAID):**
 - Tried and failed or has a contraindication or an intolerance to the preferred oral NSAIDS (excluding ketorolac) that are approved or medically accepted for the treatment of the beneficiary's diagnosis (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred oral NSAIDS in the statewide PDL class.)
 - List medications tried: _____
 - For **ALL OTHER non-preferred Migraine Acute Treatment Agents other than triptans and gepants (e.g., ditans, ergot alkaloids, etc.):**
 - Tried and failed or has a contraindication or an intolerance to the preferred drugs in this class that are approved or medically accepted for the treatment of the beneficiary's diagnosis (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
 - For a **non-preferred TRIPTAN-NSAID combination product:**
 - Tried and failed or has a contraindication or an intolerance to the preferred TRIPTANS (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred triptans in the Migraine Acute Treatment Agents class.)
 - List medications tried: _____
 - Has a clinical reason why the individual active ingredients cannot be used concurrently
 - For Symbravo (meloxicam-rizatriptan):
 - Tried and failed or has a contraindication or an intolerance to sumatriptan-naproxen

QUANTITY LIMITS/DAILY DOSE LIMITS REQUESTS

All requests that exceed the quantity limits/daily dose limits require prior authorization.

Is the requested medication prescribed by a neurologist or specialist certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)? Yes No

Is the requested quantity/dose/frequency supported by current medical compendia and/or peer-reviewed medical literature? Yes No Submit documentation.

1. For ACUTE TREATMENT OF MIGRAINE, check all that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each:

- Was evaluated for the overuse of abortive headache medications (e.g., opioids, triptans, butalbital, etc.)
- Will be using the requested medication with at least one medication for migraine prevention – specify:
 - anticonvulsant (e.g., topiramate, valproate derivative)
 - antidepressant (e.g., SNRI, TCA)
 - beta blocker (e.g., metoprolol, propranolol, timolol)
 - botulinum toxin (e.g., Botox, Dysport)
 - CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
 - gepant (e.g., Nurtec ODT, Qulipta)
 - other: _____
- Tried and failed preventive migraine medications – specify:
 - anticonvulsant (e.g., topiramate, valproate derivative)
 - antidepressant (e.g., SNRI, TCA)
 - beta blocker (e.g., metoprolol, propranolol, timolol)
 - botulinum toxin (e.g., Botox, Dysport)
 - CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
 - gepant (e.g., Nurtec ODT, Qulipta)
 - other: _____
- Has an intolerance or a contraindication to preventive migraine medications – specify:
 - anticonvulsant (e.g., topiramate, valproate derivative)
 - antidepressant (e.g., SNRI, TCA)
 - beta blocker (e.g., metoprolol, propranolol, timolol)
 - botulinum toxin (e.g., Botox, Dysport)
 - CGRP monoclonal antibody (e.g., Aimovig, Ajovy, Emgality)
 - gepant (e.g., Nurtec ODT, Qulipta)
 - other: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature: _____

Date: _____

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