OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: (Select drug below)

❑ **dihydroergotamine mesylate (D.H.E. 45®) injection**	❑ **dihydroergotamine mesylate (Migranal®) nasal spray**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Quantity Limits: Nasal spray: 8 units/30 days. Injection: 8 units/30 days.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must be 18 years of age or older and has diagnosis of acute migraine or cluster headache that causes functional impairment such as interference with activities of daily living, missed work days; etc. **(must submit chart notes documenting diagnosis and functional impairments)**

AND

- ❑ Medication has been prescribed by or in consultation with a neurologist

AND

- ❑ Member must have failed at least **TWO** different formulary 5-HT1B/1D agonist triptans taken at maximum recommended doses within the last 6 months (such as sumatriptan tablets/nasal spray/injections, rizatriptan) supported by the American Headache Society/American Academy of Neurology treatment guidelines (verified through pharmacy paid claims)

AND

- ❑ If requesting brand name Migranal® nasal spray, chart note documentation must be submitted to show member's trial and life-threatening intolerance to generic dihydroergotamine nasal spray

OR

- ❑ If requesting brand name D.H.E. 45® injections, chart note documentation must be submitted to show member's trial and life-threatening intolerance to generic dihydroergotamine injections

AND

(Continued on next page)

- ❑ Please note if the member has any of the following contraindications to therapy (request will not be approved for any of the following):
  - ❑ Coadministration with potent CYP3A4 inhibitors
  - ❑ Coadministration with peripheral or central vasoconstrictors
  - ❑ Concomitant use or use within 24 hours of 5-hydroxytryptamine-1 receptor agonists, ergotamine containing or ergot type medications, or methysergide
  - ❑ Following vascular surgery
  - ❑ Hemiplegic or basilar migraine
  - ❑ Hypersensitivity to ergot alkaloids
  - ❑ Ischemic heart disease or symptoms consistent with coronary artery vasospasm, including Prinzmetal's variant angina
  - ❑ Nursing mothers
  - ❑ Peripheral arterial disease
  - ❑ Pregnancy
  - ❑ Sepsis
  - ❑ Severe hepatic impairment
  - ❑ Severe renal impairment
  - ❑ Uncontrolled hypertension

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 9/17/2020
REVISED/UPDATED: 12/7/20