

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

**I. Requirements for Prior Authorization of Antimigraine Agents, Other**

A. Prescriptions That Require Prior Authorization

Prescriptions for Antimigraine Agents, Other that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Antimigraine Agent, Other. See the Preferred Drug List (PDL) for the list of preferred Antimigraine Agents, Other at:  
[www.providersynergies.com/services/documents/PAM\\_PDL.pdf](http://www.providersynergies.com/services/documents/PAM_PDL.pdf)

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a non-preferred Antimigraine Agent, Other, the determination of whether the requested prescription is medically necessary will take into account whether the recipient:

1. Has a diagnosis of migraine headaches according to the International Classification of Headache Disorders (ICHD) criteria

**AND**

2. Has a documented history of therapeutic failure, contraindication, or intolerance to all of the following:
  - a. NSAIDs
  - b. Triptans
  - c. Combination of a triptan and an NSAID

**AND**

3. Does not have a documented history of a contraindication to the prescribed medication

**OR**

4. Does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

For renewals of prescriptions for an Antimigraine Agent, Other: Requests for prior authorization of renewals of prescriptions for Antimigraine Agents,

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Other that were previously approved will take into account whether the recipient:

1. Experienced an improvement in migraine pain control

**AND**

2. Continues to have no documented history of a contraindication to the prescribed medication

C . Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above, to assess the medical necessity of the request for a prescription for an Antimigraine Agent, Other. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.