Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Ergot Derivatives (Dihydroergotamine)
Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select all that apply:

For the treatment of acute of migraine

- ❑ The recipient has a diagnosis of migraine headaches with or without aura.
- ❑ The medication will be used for the acute treatment of migraine.
- ❑ The medication is prescribed by or in consultation with a neurologist, pain specialist or headache specialist.
- ❑ The recipient is 18 years of age or older.
- ❑ The recipient has tried and failed or has an intolerance to two triptans.
- ❑ The recipient has a contraindication to all triptans.
- ❑ If the recipient has 4 or more headache days per month, the recipient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:
  - Elavil® (amitriptyline) or Effexor® (venlafaxine)
  - Depakote®/Depakote® ER (divalproex sodium) or Topamax® (topiramate)
  - A beta blocker (i.e., atenolol, propranolol, nadolol, timolol, metoprolol)
- ❑ If the request is for continuation of therapy, all the following:
  - The recipient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity
  - The medication is prescribed by or in consultation with a neurologist, pain specialist or headache specialist

For the treatment of cluster headache

- ❑ The recipient has a diagnosis of cluster headache.
- ❑ The medication is prescribed by or in consultation with a neurologist, pain specialist or headache specialist.
- ❑ The recipient is 18 years of age or older.
- ❑ The recipient has had a trial and failure, contraindication or intolerance to sumatriptan injection.
- ❑ If the request is for continuation of therapy, all the following:
  - The recipient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity
  - The medication is prescribed by or in consultation with a neurologist, pain specialist or headache specialist

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**