



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Dihydroergotamine Nasal Spray - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.**

Q1. Is there confirmation that the drug will not be used for prophylactic migraine therapy?

Yes

No

Q2. Is this medication being used for the acute treatment of migraine headaches with or without aura?

Yes

No

Q3. Is this member 18 years of age or older?

Yes

No

Q4. Is this medication being prescribed by or in consultation with a neurologist, headache specialist, or pain specialist?

Yes

No

Q5. Is there documentation showing an inadequate response, intolerance or contraindication to two generic triptans (such as sumatriptan, zolmitriptan, rizatriptan)?

Yes

No



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Member Name:	Prescriber Name:
Q6. Is there documentation showing an inadequate response, intolerance or contraindication to one generic triptan AND a gepant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Have all potential contraindications (including uncontrolled hypertension, use as management of hemiplegic basilar migraine, ischemic heart disease [angina pectoris, history of myocardial infarction, or documented silent ischemia] or coronary artery vasospasm including Prinzmetal's variant angina, coadministration with CYP3A4 inhibitors or peripheral and central vasoconstrictors, concomitant use or use within 24 hours of ergotamine containing or ergot type medications or methysergide, peripheral arterial disease, sepsis, following vascular surgery, severely impaired hepatic or renal function, hypersensitivity to ergot alkaloids) been excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. Requested Duration: <input type="checkbox"/> 12 Months <input type="checkbox"/> Other:	
Q9. Additional Information:	

Prescriber Signature

Date

v2025