



New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Calcitonin Gene-Related Peptide (CGRP) Inhibitors for Migraine and Cluster Headache Prevention

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of migraine, with or without aura, based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria? Yes No
2. Does the patient have a diagnosis of episodic cluster headache based on ICHD-III diagnostic criteria? Yes No

(Form continued on next page.)

