



Please complete ALL information below and fax your request to 1-888-671-5285

D.H.E. 45® (dihydroergotamine injection) Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

Select the diagnosis below:

Cluster headaches

Migraine headaches

Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is the requested medication prescribed by or in consultation with a neurologist or headache specialist? Yes No

Clinical Information:

Has the patient been instructed on proper preparation, injection, and disposal of medication? Yes No

Has the patient had inadequate response or inability to tolerate an injectable triptan? Yes No

Has the patient experienced triptan overuse, defined as using triptans greater than 8 days per month? Yes No

For brand D.H.E. 45 requests, has the patient had an inadequate response or inability to tolerate generic dihydroergotamine injection or it is not available? Yes No

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

Has the patient been examined by a neurologist within the past three years? Yes No

Select if the patient has had a trial of prophylactic treatment of the following:

<input type="checkbox"/> Beta-blocker	<input type="checkbox"/> Topiramate
<input type="checkbox"/> Calcium channel blocker	<input type="checkbox"/> Tricyclic antidepressant
<input type="checkbox"/> Cyproheptadine	<input type="checkbox"/> Valproic acid

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.

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