

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

Acute Migraine Agents 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:
<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: <input type="checkbox"/> Acute treatment of migraine <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____															
Select the medications the patient has had an inadequate response to or inability to tolerate: <table style="width: 100%; border: none;"><tr><td style="width: 33%;"><input type="checkbox"/> Almotriptan</td><td style="width: 33%;"><input type="checkbox"/> Rizatriptan</td><td style="width: 33%;"><input type="checkbox"/> Sumatriptan tablet</td></tr><tr><td><input type="checkbox"/> Eletriptan</td><td><input type="checkbox"/> Rizatriptan orally disintegrating tablet (ODT)</td><td><input type="checkbox"/> Zolmitriptan</td></tr><tr><td><input type="checkbox"/> Frovatriptan</td><td><input type="checkbox"/> Sumatriptan injection</td><td><input type="checkbox"/> Zolmitriptan ODT</td></tr><tr><td><input type="checkbox"/> Naratriptan</td><td><input type="checkbox"/> Sumatriptan nasal spray</td><td></td></tr><tr><td colspan="3"><input type="checkbox"/> Other generic triptan(s). Please specify all agent(s): _____</td></tr></table>	<input type="checkbox"/> Almotriptan	<input type="checkbox"/> Rizatriptan	<input type="checkbox"/> Sumatriptan tablet	<input type="checkbox"/> Eletriptan	<input type="checkbox"/> Rizatriptan orally disintegrating tablet (ODT)	<input type="checkbox"/> Zolmitriptan	<input type="checkbox"/> Frovatriptan	<input type="checkbox"/> Sumatriptan injection	<input type="checkbox"/> Zolmitriptan ODT	<input type="checkbox"/> Naratriptan	<input type="checkbox"/> Sumatriptan nasal spray		<input type="checkbox"/> Other generic triptan(s). Please specify all agent(s): _____		
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For Treximet/sumatriptan-naproxen requests, also answer the following: Has the patient had an inadequate response to concurrent administration of sumatriptan and naproxen as separate products? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Reauthorization: If this is a reauthorization request, answer the following: Is there documentation of positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Quantity limit requests: What is the quantity requested per MONTH? _____ Has the patient been examined by a neurologist within the past three years? <input type="checkbox"/> Yes <input type="checkbox"/> No															
Select if the patient has had a trial of prophylactic treatment of the following: <table style="width: 100%; border: none;"><tr><td style="width: 50%;"><input type="checkbox"/> Beta-blocker</td><td style="width: 50%;"><input type="checkbox"/> Calcium channel blocker</td></tr><tr><td><input type="checkbox"/> Calcitonin gene-related peptide receptor antagonist (CGRP) indicated for prophylaxis (e.g. Erenumab [Aimovig], fremanezumab [Ajovy] or galcanezumab [Emgality] 120mg)</td><td><input type="checkbox"/> Cyproheptadine</td></tr><tr><td></td><td><input type="checkbox"/> Topiramate</td></tr><tr><td></td><td><input type="checkbox"/> Tricyclic antidepressant</td></tr><tr><td></td><td><input type="checkbox"/> Valproic acid</td></tr></table>	<input type="checkbox"/> Beta-blocker	<input type="checkbox"/> Calcium channel blocker	<input type="checkbox"/> Calcitonin gene-related peptide receptor antagonist (CGRP) indicated for prophylaxis (e.g. Erenumab [Aimovig], fremanezumab [Ajovy] or galcanezumab [Emgality] 120mg)	<input type="checkbox"/> Cyproheptadine		<input type="checkbox"/> Topiramate		<input type="checkbox"/> Tricyclic antidepressant		<input type="checkbox"/> Valproic acid					
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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.