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

5HT-1 Agonist (Triptan) 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:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Acute migraines (with or without aura)
❑ Cluster headache
❑ Other diagnosis: ______________________________ ICD-10 Code(s): ______________________________

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Naratriptan
❑ Rizatriptan orally disintegrating tablet (ODT)
❑ Rizatriptan tablet
❑ Sumatriptan nasal spray
❑ Sumatriptan tablet
❑ Zolmitriptan ODT
❑ Zolmitriptan tablet
❑ Other 5-HT1 receptor agonist (triptan) alternative(s). Please specify: ____

Quantity limit requests:

What is the quantity requested per MONTH? _______

Does the patient experience 2 or more headaches monthly? ❑ **Yes** ❑ **No**

Will the patient be treating 15 or more headaches monthly? ❑ **Yes** ❑ **No**

Was the requested medication prescribed by or in consultation with a neurologist or pain management specialist? ❑ **Yes** ❑ **No**

Is the requested medication being used in combination with another triptan or ergotamine-containing product? ❑ **Yes** ❑ **No**

Select the prophylactic therapies the patient is currently receiving:

❑ Antidepressants (e.g., amitriptyline, venlafaxine)
❑ Anticonvulsants (e.g., divalproex, topiramate)
❑ Beta-blockers (e.g., metoprolol, propranolol, timolol)

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

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Please note: This request may be denied unless all required information is received.

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