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

Imitrex® injection (sumatriptan), Sumavel® DosePro®, & Zembrace® SymTouch®
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): ________________________________

Quantity Limit Requests:

What is the quantity requested per MONTH? ______

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

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

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

Select if the patient is currently receiving prophylactic therapy with the following therapies:
- ❑ Antidepressants (e.g., amitriptyline, venlafaxine)
- ❑ Anticonvulsants (e.g., divalproex, topiramate)
- ❑ Beta-blockers (e.g., metoprolol, propranolol, timolol)

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

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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