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:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Acute treatment of migraine

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

Select the medications the patient has had an inadequate response to or inability to tolerate:

❑ Almotriptan
❑ Eletriptan
❑ Frovatriptan
❑ Naratriptan
❑ Rizatriptan
❑ Rizatriptan orally disintegrating tablet (ODT)
❑ Sumatriptan injection
❑ Sumatriptan nasal spray
❑ Sumatriptan tablet
❑ Zolmitriptan
❑ Zolmitriptan ODT

❑ Other generic triptan(s). Please specify all agent(s): _____

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? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following:

Is there documentation of positive clinical response to therapy? ❑ **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:

❑ Beta-blocker
❑ Calcitonin gene-related peptide receptor antagonist (CGRP) indicated for prophylaxis (e.g. Erenumab [Aimovig], fremanezumab [Ajovy] or galcanezumab [Emgality] 120mg)
❑ Calcium channel blocker
❑ Cyproheptadine
❑ Topiramate
❑ Tricyclic antidepressant
❑ 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.