



Prior Authorization Form

Migraine Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)* **Amerge®** (naratriptan) **Axert®** (almotriptan) **Frova®** (frovatriptan)
 Maxalt® (rizatriptan) **Migranal®** (dihydroergotamine NS) **Treximet®**
 Relpax® (eletriptan) **Stadol NS®** (butorphanol) **other:** _____
 Zomig® (zolmitriptan) **Imitrex®** (sumatriptan) **Oral** **Nasal** **Injection**

Date: _____ Patient ID#: _____ DOB: _____
 Patient Name: _____ Provider NPI: _____
 Prescribing Physician: _____ Drug Strength: _____ Quantity Requested: _____
 Office Fax #: _____ Office Phone: _____ Office Contact: _____

MIGRAINE AGENTS (Please note, prior authorization is required for quantities exceeding those listed below in a rolling 30-day period).

Medication	Dosage Form	Quantity Limit (within 30 days)
Amerge® (naratriptan)	1 mg tablets	23 tablets
Amerge® (naratriptan)	2.5 mg tablets	9 tablets
Axert® (almotriptan)	6.25 mg tablets	24 tablets
Axert® (almotriptan)	12.5 mg tablets	12 tablets
Frova® (frovatriptan)	2.5 mg tablets	18 tablets
Imitrex® (sumatriptan)	25 mg tablets	72 tablets
Imitrex® (sumatriptan)	50 mg tablets	36 tablets
Imitrex® (sumatriptan)	100 mg tablets	18 tablets
Imitrex® (sumatriptan)	6 mg injection	9 kits (18 injections)
Imitrex® (sumatriptan)	5 mg nasal spray	72 units
Imitrex® (sumatriptan)	20 mg nasal spray	18 units
Maxalt® and Maxalt MLT® (rizatriptan)	5 mg tablets	24 tablets
Maxalt® and Maxalt MLT® (rizatriptan)	10 mg tablets	12 tablets
Relpax® (eletriptan)	20 mg tablets	24 tablets
Relpax® (eletriptan)	40 mg tablets	12 tablets
Zomig® and Zomig ZMT® (zolmitriptan)	2.5 mg tablets	18 tablets
Zomig® and Zomig ZMT® (zolmitriptan)	5 mg tablets	9 tablets
Zomig NS® (zolmitriptan)	5 mg nasal spray	9 units
Migranal® (dihydroergotamine)	4 mg nasal spray	8 units (2 kits)
Stadol NS® (butorphanol)	10 mg nasal spray	4 units

Patient History:

Has the patient been seen by a neurologist within the past 3 years? Yes No
 Is the patient currently, or has been, on prophylactic drug therapy for migraines? Yes No
 Does the patient have a history of trial and failure of concurrent therapy with
 Imitrex and Naproxen containing product? Yes No

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only	Coverage effective date / /
Document # _____	Processor Initials _____ Date _____
M F Rx coverage Y N	STANDARD - SELECT LOB _____

Previous Auth	Y	N	Approved	Reviewer Initials _____	Date _____
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