AmeriHealth

Migraine Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)*

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

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
Treximet® (sumatriptan/naproxen)	85mg/500mg tablets	18 units
Sumavel® (sumatriptan succinate)	6mg/0.5ml	18 units

Patient History:

MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

Drug Name (dose and frequency)	Duration of therapy (include dates)	Currently prescribed
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Does the patient have a diagnosis of migraine headaches?	☐ Yes ☐ No
Does the patient have a diagnosis of cluster headaches?	☐ Yes ☐ No
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

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