



## Migraine Agents

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested: *(check one)*

<input type="checkbox"/> <b>Amerge®</b> (naratriptan)	<input type="checkbox"/> <b>Axert®</b> (almotriptan)	<input type="checkbox"/> <b>Frova®</b> (frovatriptan)
<input type="checkbox"/> <b>Maxalt®</b> (rizatriptan)	<input type="checkbox"/> <b>Migranal®</b> (dihydroergotamine NS)	<input type="checkbox"/> <b>Treximet®</b>
<input type="checkbox"/> <b>Relpax®</b> (eletriptan)	<input type="checkbox"/> <b>Stadol NS®</b> (butorphanol)	<input type="checkbox"/> <b>other:</b> _____
<input type="checkbox"/> <b>Zomig®</b> (zolmitriptan)	<input type="checkbox"/> <b>Imitrex®</b> (sumatriptan)	
<input type="checkbox"/> Oral <input type="checkbox"/> Nasal	<input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> 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
Treximet® (sumatriptan/naproxen)	85mg/500mg tablets	18 units
Sumavel® (sumatriptan succinate)	6mg/0.5ml	18 units

**Patient History:**

Does the patient have a diagnosis of migraine headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient have a diagnosis of cluster headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient been seen by a neurologist within the past 3 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient currently, or has been, on prophylactic drug therapy for migraines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient have a history of trial and failure of concurrent therapy with Imitrex and Naproxen containing product?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient tried and failed or has a contraindication to sumatriptan (Imitrex) vials or pen injectors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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