

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

Acute Migraine Agents Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)
Select the diagnosis below: <input type="checkbox"/> Acute treatment of migraine <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Select the medications the patient has had an inadequate response to or inability to tolerate: <input type="checkbox"/> Almotriptan <input type="checkbox"/> Rizatriptan <input type="checkbox"/> Sumatriptan tablet <input type="checkbox"/> Eletriptan <input type="checkbox"/> Rizatriptan orally disintegrating tablet (ODT) <input type="checkbox"/> Zolmitriptan <input type="checkbox"/> Frovatriptan <input type="checkbox"/> Sumatriptan injection <input type="checkbox"/> Zolmitriptan ODT <input type="checkbox"/> Naratriptan <input type="checkbox"/> Sumatriptan nasal spray <input type="checkbox"/> Other generic triptan(s). Please specify all agent(s): _____
For sumatriptan-naproxen requests, also answer the following: Has the patient had an inadequate response to concurrent administration of sumatriptan and naproxen as separate products? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reauthorization: If this is a reauthorization request, answer the following: Is there documentation of positive clinical response to therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Quantity limit requests: What is the quantity requested per MONTH? _____ Has the patient been examined by a neurologist within the past three years? <input type="checkbox"/> Yes <input type="checkbox"/> No
Select if the patient has had a trial of prophylactic treatment of the following: <input type="checkbox"/> Beta-blocker <input type="checkbox"/> Calcium channel blocker <input type="checkbox"/> Calcitonin gene-related peptide receptor antagonist (CGRP) indicated for prophylaxis (e.g. Erenumab [Aimovig], fremanezumab [Ajovy] or galcanezumab [Emgality] 120mg) <input type="checkbox"/> Cyproheptadine <input type="checkbox"/> Topiramate <input type="checkbox"/> Tricyclic antidepressant <input type="checkbox"/> 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.

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