

ANTIMIGRAINE AGENTS, TRIPTANS PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Antimigraine Agents, Triptans, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antimigraine Agents, Triptans** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name:		
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:		NPI:	MA Provider ID#:		
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

CLINICAL INFORMATION

Non-preferred medication requested:			
<input type="checkbox"/> almotriptan tablet	<input type="checkbox"/> Imitrex injection vial	<input type="checkbox"/> sumatriptan SQ injection syringe	<input type="checkbox"/> zolmitriptan ODT
<input type="checkbox"/> Alsuma injection	<input type="checkbox"/> Maxalt MLT	<input type="checkbox"/> Sumavel DosePro SQ injection	<input type="checkbox"/> Zomig tablet
<input type="checkbox"/> Amerge tablet	<input type="checkbox"/> Maxalt tablet	<input type="checkbox"/> Treximet tablet	<input type="checkbox"/> Zomig ZMT
<input type="checkbox"/> Axert tablet	<input type="checkbox"/> naratriptan tablet	<input type="checkbox"/> Zecuity patch	<input type="checkbox"/> Zomig nasal spray
<input type="checkbox"/> Frova tablet	<input type="checkbox"/> sumatriptan nasal spray	<input type="checkbox"/> zolmitriptan tablet	<input type="checkbox"/> _____
<input type="checkbox"/> Imitrex tablet	<input type="checkbox"/> sumatriptan SQ injection cartridge kit		
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	

ALL non-preferred requests

1. Has the Recipient tried and failed any of the following preferred Antimigraine Agents, Triptans? <i>Check all that apply.</i>			<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimens tried and treatment outcomes</i> <input type="checkbox"/> No
Oral	Nasal	SQ injection	
<input type="checkbox"/> Relpax tablet	<input type="checkbox"/> rizatriptan ODT	<input type="checkbox"/> Imitrex nasal spray	
<input type="checkbox"/> rizatriptan tablet	<input type="checkbox"/> sumatriptan tablet	<input type="checkbox"/> sumatriptan SQ injection pen or cartridge kit	
2. Does the Recipient have any contraindications or intolerances to the preferred Antimigraine Agents, Triptans listed in question (1)?			<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication names and associated intolerances and contraindications</i> <input type="checkbox"/> No

ALL requests for exceeding the quantity limit

1. Does the Recipient have an evaluation showing a diagnosis of chronic, severe migraine as per the International Classification of Headache Disorders (ICHD) criteria?		<input type="checkbox"/> Yes – <i>submit documentation of evaluation</i> <input type="checkbox"/> No
2. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the following medication classes used for migraine prevention? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication names and associated intolerances and contraindications</i> <input type="checkbox"/> No
<input type="checkbox"/> anticonvulsants	<input type="checkbox"/> calcium channel blockers	<input type="checkbox"/> TCAs
<input type="checkbox"/> beta blockers	<input type="checkbox"/> NSAIDs	<input type="checkbox"/> SSRIs

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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