

Pharmacy Request for Prior Approval - Triptans

Recipient Information

1. Recipient Last Name: _____ 2. First Name: _____
 3. Recipient ID #: _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:
 8. Prescriber DEA #: _____
 Requester Contact Information Name: _____ Phone #: _____ Ext: _____

Drug Information

9a. Drug Name: _____ 9b. Is this request for a Non-Preferred Drug? Yes No
 10. Strength: _____ 11. Quantity Per 30 Days: _____
 12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

Request for Non-Preferred Drug:

1. Failed two preferred drug(s). List preferred drugs failed: _____
 1a. Allergic Reaction 1b. Drug-to-drug interaction. Please describe reaction: _____
2. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
3. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
 Please provide clinical information: _____
4. Age specific indications. Please give patient age and explain: _____
5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____
6. Unacceptable clinical risk associated with therapeutic change. Please explain: _____

Request for Exceeding Quantity Limit (Check all that apply.)

7. Does the patient have a diagnosis of migraine or cluster headache? Yes No
8. Does the patient have more than 6 moderate or severe headache days per month? Yes No
9. Does the patient have a history of NSAID therapy in the past year? Yes No
10. Does the patient have a contraindication or allergy to NSAID therapy? Yes No
11. Is the patient currently receiving therapy with a migraine preventative? Yes No
12. Does the patient have a contraindication or history of an adverse reaction with preventative medications? Yes No
 Please list: _____
13. Did the patient have no clinical benefit after at least a 90 day trial of preventative medications at the maximum tolerated dose? Yes No
14. Has the patient been diagnosed with Ischemic Heart Disease, Peripheral Vascular Disease, Cerebrovascular Disease, Ischemic Bowel Disease, or Hemiplegic Migraine? Yes No
15. Has the patient received an MAO Inhibitor in the past 2 weeks? Yes No
16. Will the beneficiary have concurrent use of (or use within 24 hours) ergotamine-containing or ergot-type medication? Yes No
17. Will the beneficiary have concurrent use of (or use within 24 hours) another 5-HT₁ agonist? Yes No
18. Does the patient have uncontrolled hypertension or basilar migraine? Yes No
19. Has the prescriber reviewed the DHB evidenced-based recommendations on the treatment of migraine? Yes No

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Prescriber: _____

Date: _____

Fax this form to: (877) 386-4695

Pharmacy PA Call Center: (833) 585-4309