

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.  
Allow at least 24 hours for review.**

**Section A – Member Information**

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

**Section B - Provider Information**

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

**Section C - Medical Information**

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

**Section D – Previous Medication Trials**

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:  
Please refer to the patient's PDL for a list of preferred alternatives**

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a diagnosis of <u>migraine headaches with or without aura</u>?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure, contraindication, or intolerance any of the preferred products?</b> <i>(If yes, complete Section D above)</i>

**QUANTITY LIMIT REQUESTS**

*\*\*Please provide any evidence to support safety and additional efficacy at higher than maximum FDA approved doses\*\**

DRUG NAME	STRENGTH	QUANTITY LIMIT
Amerge (naratriptan)	1mg, 2.5mg	9 tabs/month
Frova	2.5mg	9 tabs/month
Imitrex (sumatriptan)	25mg, 50mg, 100mg	9 tabs/month
Maxalt (rizatriptan)	5mg, 10mg	9 tabs/month
Maxalt MLT (rizatriptan)	5mg, 10mg	9 tabs/month
Axert	6.25mg, 12.5mg	6 tabs/month
Relpax	20mg, 40mg	6 tabs/month
Zomig (zolmitriptan)	2.5mg	6 tabs/month
Zomig ZMT (zolmitriptan)	2.5mg	6 tabs/month
Imitrex (sumatriptan) nasal spray	5mg, 20mg	6 spray devices/month
Zomig Nasal Spray	5mg	2 sprays/day
Treximet	85mg/500mg, 10mg/60mg	9 tabs/month
Zomig (zolmitriptan)	5mg	6 tabs/month
Zomig ZMT (zolmitriptan ODT)	5mg	6 tabs/month
SumaChip (sumatriptan & capsaicin-menthol)	100mg tab & capsaicin menthol 0.0375%	1 box (39 units)/month
Onzetra Xsail	11 mg	1 box (8 units)/month
Zembrace SymTouch	3 mg	1 box (4 units)/month
Sumavel DosePro	6 mg	1 box (6 units)/month
Imitrex (sumatriptan) injection	4mg, 6mg	2 devices/month

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the requested dosage meet the plan's quantity limit?</b> <i>(See Table above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the requested medication prescribed by, or in consultation, with a neurologist or pain management specialist?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient experiencing <u>two or more</u> headaches monthly?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient currently receiving prophylactic therapy with at least <u>ONE</u> of the following?</b> <i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Antidepressants [e.g., Elavil (amitriptyline), Effexor (venlafaxine)]</li> <li><input type="checkbox"/> Antihistamines (e.g., cyproheptadine)</li> <li><input type="checkbox"/> Antiepileptics [e.g., Depakote/Depakote ER (divalproex sodium), Topamax (topiramate)]</li> <li><input type="checkbox"/> ACE Inhibitors [e.g., Zestril (lisinopril)]</li> <li><input type="checkbox"/> Angiotension receptor blockers [e.g., Atacand (candesartan)]</li> <li><input type="checkbox"/> Alpha-agonists (e.g., clonidine, guanfacine)</li> <li><input type="checkbox"/> Beta-blockers [e.g., Inderal (propranolol), timolol, Toprol XL (metoprolol)]</li> </ul>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the provider acknowledge that the potential benefit outweighs the risk associated with the higher dose or quantity?</b>

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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