UnitedHealthcare Community Plan

Triptans
Prior Authorization Request Form

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: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ 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? □ Yes □ 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

UnitedHealthcare Community Plan

Triptans
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

□ Yes □ No	**Does the patient have a diagnosis of migraine headaches with or without aura?**
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance any of the preferred products?** *(If yes, complete Section D above)*

NARATRIPTAN

□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to Imitrex (sumatriptan)?** *(If yes, complete Section D above)*

QUANTITY LIMIT REQUESTS

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

□ Yes □ No	**Does the requested dosage meet the plan's quantity limit?** *(See Table above)*
□ Yes □ No	**Is the requested medication prescribed by, or in consultation, with a neurologist or pain management specialist?**
□ Yes □ No	**Is the patient experiencing <u>two or more</u> headaches monthly?**
□ Yes □ No	**Is the patient currently receiving prophylactic therapy with at least <u>ONE</u> of the following?** *(If yes, check which applies)* □ Antidepressants [e.g., Elavil (amitriptyline), Effexor (venlafaxine)] □ Antihistamines (e.g., cyproheptadine) □ Antiepileptics [e.g., Depakote/Depakote ER (divalproex sodium), Topamax (topiramate)] □ ACE Inhibitors [e.g., Zestril (lisinopril)] □ Angiotensin receptor blockers [e.g., Atacand (candesartan)] □ Alpha-agonists (e.g., clonidine, guanfacine) □ Beta-blockers [e.g., Inderal (propranolol), Timolol, Toprol XL (metoprolol)]
□ Yes □ No	**Does the provider acknowledge that the potential benefit outweighs the risk associated with the higher dose or quantity?**

Provider Signature: _____ **Date:** _____