



Migraine Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)*

<input type="checkbox"/> Amerge® (naratriptan)	<input type="checkbox"/> Axert® (almotriptan)	<input type="checkbox"/> Frova® (frovatriptan)
<input type="checkbox"/> Maxalt® (rizatriptan)	<input type="checkbox"/> Migranal® (dihydroergotamine NS)	<input type="checkbox"/> Treximet®
<input type="checkbox"/> Relpax® (eletriptan)	<input type="checkbox"/> Stadol NS® (butorphanol)	<input type="checkbox"/> other: _____
<input type="checkbox"/> Zomig® (zolmitriptan)	<input type="checkbox"/> Imitrex® (sumatriptan)	
<input type="checkbox"/> Oral <input type="checkbox"/> Nasal	<input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Injection	

Date: _____ Patient ID#: _____ DOB: _____
 Patient Name: _____ Provider NPI: _____
 Prescribing Physician: _____ Drug Strength: _____ Quantity Requested: _____
 Office Fax #: _____ Office Phone: _____ Office Contact: _____

MIGRAINE AGENTS (Please note, prior authorization is required for quantities exceeding those listed below in a rolling 30-day period).

Medication	Dosage Form	Quantity Limit (within 30 days)
Amerge® (naratriptan)	1 mg tablets	23 tablets
Amerge® (naratriptan)	2.5 mg tablets	9 tablets
Axert® (almotriptan)	6.25 mg tablets	24 tablets
Axert® (almotriptan)	12.5 mg tablets	12 tablets
Frova® (frovatriptan)	2.5 mg tablets	18 tablets
Imitrex® (sumatriptan)	25 mg tablets	72 tablets
Imitrex® (sumatriptan)	50 mg tablets	36 tablets
Imitrex® (sumatriptan)	100 mg tablets	18 tablets
Imitrex® (sumatriptan)	6 mg injection	9 kits (18 injections)
Imitrex® (sumatriptan)	5 mg nasal spray	72 units
Imitrex® (sumatriptan)	20 mg nasal spray	18 units
Maxalt® and Maxalt MLT® (rizatriptan)	5 mg tablets	24 tablets
Maxalt® and Maxalt MLT® (rizatriptan)	10 mg tablets	12 tablets
Relpax® (eletriptan)	20 mg tablets	24 tablets
Relpax® (eletriptan)	40 mg tablets	12 tablets
Zomig® and Zomig ZMT® (zolmitriptan)	2.5 mg tablets	18 tablets
Zomig® and Zomig ZMT® (zolmitriptan)	5 mg tablets	9 tablets
Zomig NS® (zolmitriptan)	5 mg nasal spray	9 units
Migranal® (dihydroergotamine)	4 mg nasal spray	8 units (2 kits)
Stadol NS® (butorphanol)	10 mg nasal spray	4 units
Treximet® (sumatriptan/naproxen)	85mg/500mg tablets	18 units
Sumavel® (sumatriptan succinate)	6mg/0.5ml	18 units

Patient History:

MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

Drug Name (dose and frequency)	Duration of therapy (include dates)	Currently prescribed	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient have a diagnosis of migraine headaches?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient have a diagnosis of cluster headaches?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient been seen by a neurologist within the past 3 years?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient currently, or has been, on prophylactic drug therapy for migraines?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.