OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

5HT-1 Agonist (Triptan) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:
❑ Acute migraines (with or without aura)
❑ Cluster headache
❑ Other diagnosis: ____________________________ ICD-10 Code(s): ____________________________

Select the medications the patient has a failure, contraindication, or intolerance to:
❑ Imitrex
❑ Maxalt
❑ Maxalt-MLT
❑ Naratriptan
❑ Rizatriptan
❑ Rizatriptan orally disintegrating tablet (ODT)
❑ Sumatriptan nasal spray
❑ Sumatriptan tablet
❑ Zolmitriptan
❑ Zolmitriptan ODT
❑ Zomig
❑ Zomig-ZMT
❑ Other 5-HT1 receptor agonist (triptan) alternative(s). Please specify: ____

Quantity limit requests:
What is the quantity requested per MONTH? ______
Does the patient experience 2 or more headaches monthly? ❑ **Yes** ❑ **No**
Will the patient be treating 15 or more headaches monthly? ❑ **Yes** ❑ **No**
Was the requested medication prescribed by or in consultation with a neurologist or pain management specialist? ❑ **Yes** ❑ **No**
Is the requested medication being used in combination with another triptan or ergotamine-containing product? ❑ **Yes** ❑ **No**

Select the prophylactic therapies the patient is currently receiving:
❑ Antidepressants (e.g., amitriptyline, venlafaxine)
❑ Anticonvulsants (e.g., divalproex, topiramate)
❑ Beta-blockers (e.g., metoprolol, propranolol, timolol)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
Office use only: 5HT1Agonist_Comm_2018Nov-W