



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

Imitrex[®] injection (sumatriptan), Sumavel[®] DosePro[®], & Zembrace[®] SymTouch[®] Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>	
Select the diagnosis below:	
<input type="checkbox"/> Acute migraines (with or without aura)	
<input type="checkbox"/> Cluster headache	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

For acute migraines (with or without aura), answer the following:

For Imitrex injection, sumatriptan injection, or Sumavel DosePro requests:

Select if the patient has history of failure, contraindication, or intolerance to the following:

<input type="checkbox"/> Almotriptan	<input type="checkbox"/> Rizatriptan orally disintegrating tablet (ODT)
<input type="checkbox"/> Frovalriptan	<input type="checkbox"/> Sumatriptan nasal spray
<input type="checkbox"/> Imitrex	<input type="checkbox"/> Sumatriptan tablets
<input type="checkbox"/> Maxalt	<input type="checkbox"/> Zolmitriptan
<input type="checkbox"/> Maxalt MLT	<input type="checkbox"/> Zolmitriptan ODT
<input type="checkbox"/> Naratriptan	<input type="checkbox"/> Zomig
<input type="checkbox"/> Rizatriptan	<input type="checkbox"/> Zomig-ZMT
<input type="checkbox"/> Other 5-HT1 agonist (triptan) alternative(s): _____	

Is the patient unable to take medications by mouth? Yes No

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

Was the requested medication prescribed by or in consultation with a neurologist or pain management specialist? Yes No

Does the patient experience 2 or more headaches monthly? Yes No

Will the patient be treating 15 or more headaches monthly? Yes No

Select if the patient is currently receiving prophylactic therapy with the following therapies:

<input type="checkbox"/> Antidepressants (e.g., amitriptyline, venlafaxine)
<input type="checkbox"/> Anticonvulsants (e.g., divalproex, topiramate)
<input type="checkbox"/> Beta-blockers (e.g., metoprolol, propranolol, timolol)

Is the requested medication being used in combination with another triptan or ergotamine-containing product? Yes No

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Office use only: Imitrexinjection-sumatriptan-SumavelDosePro-ZembraceSymTouch_Comm_2018Feb-W



**Imitrex[®] injection (sumatriptan), Sumavel[®] DosePro[®], & Zembrace[®] SymTouch[®]
Prior Authorization Request Form (Page 2 of 2)**

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

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.