



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:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Migraine headache	
<input type="checkbox"/> Other diagnosis: _____	ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:	
<input type="checkbox"/> Almotriptan	<input type="checkbox"/> Rizatriptan orally disintegrating tablet (ODT)
<input type="checkbox"/> Amerge	<input type="checkbox"/> Sumatriptan nasal spray
<input type="checkbox"/> Eletriptan	<input type="checkbox"/> Sumatriptan tablet
<input type="checkbox"/> Frova	<input type="checkbox"/> Zolmitriptan
<input type="checkbox"/> Frovatriptan	<input type="checkbox"/> Zolmitriptan ODT
<input type="checkbox"/> Imitrex nasal spray	<input type="checkbox"/> Zomig
<input type="checkbox"/> Naratriptan	<input type="checkbox"/> Zomig nasal spray
<input type="checkbox"/> Rizatriptan	<input type="checkbox"/> Zomig ZMT

Quantity limit requests:
What is the quantity requested per MONTH? _____
Does the patient experience two or more headaches monthly? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the prescriber attest that in his/her clinical judgement, a higher dose or quantity is medically necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the prescriber attest that the number of doses available under the current restriction has been ineffective in the treatment of the patient's disease or medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the prescriber acknowledge that the safety of treating frequent headaches in a 30-day period has not been established, according to the package labeling of multiple triptan products? <input type="checkbox"/> Yes <input type="checkbox"/> No

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. If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555. 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.

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