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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Migraine headache
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Almotriptan
❑ Amerge
❑ Eletriptan
❑ Frova
❑ Frovatriptan
❑ Imitrex nasal spray
❑ Naratriptan
❑ Rizatriptan
❑ Rizatriptan orally disintegrating tablet (ODT)
❑ Sumatriptan nasal spray
❑ Sumatriptan tablet
❑ Zolmitriptan
❑ Zolmitriptan ODT
❑ Zomig
❑ Zomig nasal spray
❑ Zomig ZMT

Quantity limit requests:

What is the quantity requested per MONTH? _____

Does the patient experience two or more headaches monthly? ❑ **Yes** ❑ **No**

Does the prescriber attest that in his/her clinical judgement, a higher dose or quantity is medically necessary? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **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.