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

Treximet® (sumatriptan-naproxen) 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
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication history:

Has the patient had a history of failure, contraindication, or intolerance to sumatriptan-naproxen? ❑ **Yes** ❑ **No**

Does the patient have a history of failure, contraindication, or intolerance to a triptan (Imitrex or sumatriptan) ***used in combination*** with a nonsteroidal anti-inflammatory drug (NSAID) [EC-Naprosyn, naproxen, naproxen delayed-release (DR), naproxen sodium, or naproxen sodium extended-release (ER)]? ❑ **Yes** ❑ **No**

If YES, please indicate ALL specific combinations: _____

_____

_____

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.

Office use only: Treximet_CMS_2019Jan1-W