

Triptans 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			Directions for Use:		
Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
0		ICD-10 Code(s):			
Other diagnosis: ICD-10 Code(s): Medication history:					
Has the patient had a trial and failure of a generic triptan within the last 6 months? U Yes U No					
Quantity limit requests:					
What is the quantity requested per MONTH?					
What is the reason for exceeding the plan limitations?					
 Titration or loading dose purposes Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two 					
tablets at bedtime)					
Requested strength/dose is not commercially available					
Other:					
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 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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