Prior Authorization Request Form - Anti-Migraine Triptans

Instructions:

This form is to be used by participating providers to request coverage for anti-migraine drugs requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
Fax: 1-800-918-7542

An anti-migraine step therapy program has been developed to encourage the use of first-line serotonin agonist anti-migraine products before second-line products are used for the same indication**.**	
First-line therapies: Amerge sumatriptan Relpax Zomig	**Second-Line therapies:** Axert Frova Maxalt & Maxalt-MLT

**Please note – This form is for prior authorization use only. NHP has monthly quantity limits on triptans. For a complete list of quantity limits, please refer to NHP website at www.nhp.org and choose the pharmacy section.

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
4. Prescriber's FULL Name & Specialty:	5. Contact Person at Office:	
6. Prescriber's Fax Number & Telephone Number: Fax: ( ) Tel: ( ) Mailing address:		
7. Requested drug: ☐ Axert ☐ Frova ☐ Maxalt ☐ Maxalt-MLT	8. Dose, Frequency and Duration of Requested Drug:	
9. Number of tablets requested per month:		
10. Is the member having 2 or more migraines per week? ☐ Yes ☐ No If Yes, please specify quantity: _____		
11. Is the member currently using migraine prophylaxis? ☐ Yes ☐ No If Yes, please specify: _____		
12. Has the patient been started & stabilized on Axert, Frova or Maxalt within the last 180 days? ☐ Yes ☐ No - If 'yes', duration of therapy = _____		
13. Has the patient been seen by a neurologist or headaches specialist in the past year? ☐ Yes ☐ No - If 'yes', please indicate the date of consult: _____		

14. Has the member previously tried the following?

Drug Name (please check all that apply)	**Response (please check all that apply)**
☐ Amerge	☐ side effect _____ ☐ non-response ☐ allergy
☐ sumatriptan	☐ side effect _____ ☐ non-response ☐ allergy
☐ Relpax	☐ side effect _____ ☐ non-response ☐ allergy
☐ Zomig	☐ side effect _____ ☐ non-response ☐ allergy

15. Prescriber comments

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature Date