



Migraine Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) **Amerge®** (naratriptan) **Axert®** (almotriptan) **Frova®** (frovatriptan)
 Maxalt® (rizatriptan) **Migranal®** (dihydroergotamine NS) **Treximet®**
 Relpax® (eletriptan) **Stadol NS®** (butorphanol)
 Zomig® (zolmitriptan) **Imitrex®** (sumatriptan) **other:** _____
 Oral Nasal Oral Nasal Injection

Date: _____ Patient ID#: _____ DOB: _____
 Patient Name: _____ Provider NPI: _____
 Prescribing Physician: _____ Drug Strength: _____ Quantity Requested: _____
 Office Fax #: _____ Office Phone: _____ Office Contact: _____

MIGRAINE AGENTS (Please note, prior authorization is required for quantities exceeding those listed below in a rolling 30-day period).

| Medication | Dosage Form | Quantity Limit (within 30 days) |
|---------------------------------------|--------------------|---------------------------------|
| Amerge® (naratriptan) | 1 mg tablets | 23 tablets |
| Amerge® (naratriptan) | 2.5 mg tablets | 9 tablets |
| Axert® (almotriptan) | 6.25 mg tablets | 24 tablets |
| Axert® (almotriptan) | 12.5 mg tablets | 12 tablets |
| Frova® (frovatriptan) | 2.5 mg tablets | 18 tablets |
| Imitrex® (sumatriptan) | 25 mg tablets | 72 tablets |
| Imitrex® (sumatriptan) | 50 mg tablets | 36 tablets |
| Imitrex® (sumatriptan) | 100 mg tablets | 18 tablets |
| Imitrex® (sumatriptan) | 6 mg injection | 9 kits (18 injections) |
| Imitrex® (sumatriptan) | 5 mg nasal spray | 72 units |
| Imitrex® (sumatriptan) | 20 mg nasal spray | 18 units |
| Maxalt® and Maxalt MLT® (rizatriptan) | 5 mg tablets | 24 tablets |
| Maxalt® and Maxalt MLT® (rizatriptan) | 10 mg tablets | 12 tablets |
| Relpax® (eletriptan) | 20 mg tablets | 24 tablets |
| Relpax® (eletriptan) | 40 mg tablets | 12 tablets |
| Zomig® and Zomig ZMT® (zolmitriptan) | 2.5 mg tablets | 18 tablets |
| Zomig® and Zomig ZMT® (zolmitriptan) | 5 mg tablets | 9 tablets |
| Zomig NS® (zolmitriptan) | 5 mg nasal spray | 9 units |
| Migranal® (dihydroergotamine) | 4 mg nasal spray | 8 units (2 kits) |
| Stadol NS® (butorphanol) | 10 mg nasal spray | 4 units |
| Treximet® (sumatriptan/naproxen) | 85mg/500mg tablets | 18 units |
| Sumavel® (sumatriptan succinate) | 6mg/0.5ml | 18 units |

Patient History:

MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

| Drug Name (dose and frequency) | Duration of therapy (include dates) | Currently prescribed |
|--|-------------------------------------|--|
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the patient have a diagnosis of migraine headaches? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Does the patient have a diagnosis of cluster headaches? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Has the patient been seen by a neurologist within the past 3 years? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the patient currently, or has been, on prophylactic drug therapy for migraines? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL