



Request for Prior Authorization
SEROTONIN 5-HT1 RECEPTOR AGONISTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for quantities exceeding 12 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation.

Preferred (PA required after 12 doses in 30 days)

- Imitrex Injectable
Imitrex Nasal Spray
Naratriptan
Rizatriptan ODT
Rizatriptan Tablets
Sumatriptan Tablets

Non- Preferred (PA required from Day 1)

- Almotriptan
Amerge
Axert
Frova
Frovatriptan
Imitrex Tabs
Maxalt
Maxalt MLT
Relpax
Sumatriptan NS
Sumatriptan Inj
Sumavel DosePro
Treximet\*
Zolmitriptan
Zomig
Zomig ZMT

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis:

If Migraine, please document the current prophylactic therapy or 2 previous trials and therapy failures with two different prophylactic medications including drug names, strength, exact date ranges and failure reasons:

Medical or contraindication reason to override trial requirements:

Previous migraine therapy (include drug/dose/duration):

Reason for use of Non-Preferred drug requiring prior approval:

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.