PRO ACT PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

5HT-1 Agonist (Triptan) Prior Authorization Request Form (Page 1 of 2)

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:

❑ Acute migraines (with or without aura)
❑ Cluster headache
❑ Other diagnosis:_____ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Almotriptan
❑ Frovatriptan
❑ Imitrex
❑ Maxalt
❑ Maxalt-MLT
❑ Naratriptan
❑ Rizatriptan
❑ Rizatriptan orally disintegrating tablet (ODT)
❑ Sumatriptan nasal spray
❑ Sumatriptan tablets
❑ Zolmitriptan
❑ Zolmitriptan ODT
❑ Zomig
❑ Zomig-ZMT
❑ Other 5-HT1 agonist (triptan) alternative(s). Please specify: _____

Quantity limit requests:

What is the quantity requested per MONTH? _____

Does the patient experience 2 or more headaches monthly? ❑ **Yes** ❑ **No**

Will the patient be treating 15 or more headaches monthly? ❑ **Yes** ❑ **No**

Was the requested medication prescribed by or in consultation with a neurologist or pain management specialist? ❑ **Yes** ❑ **No**

Is the requested medication being used in combination with another triptan or ergotamine-containing product? ❑ **Yes** ❑ **No**

Select the prophylactic therapies the patient is currently receiving:

❑ Antidepressants (e.g., amitriptyline, venlafaxine)
❑ Anticonvulsants (e.g., divalproex, topiramate)
❑ Beta-blockers (e.g., metoprolol, propranolol, timolol)

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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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	