Independence Blue Cross

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 — ☐ Oral ☐ Nasal)
- ☐ **Imitrex®** (sumatriptan) — ☐ Oral ☐ Nasal ☐ Injection
- ☐ **other:** _____

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
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Does the patient have a diagnosis of migraine headaches?	☐ Yes ☐ No
Does the patient have a diagnosis of cluster headaches?	☐ Yes ☐ No
Has the patient been seen by a neurologist within the past 3 years?	☐ Yes ☐ No
Is the patient currently, or has been, on prophylactic drug therapy for migraines?	☐ Yes ☐ No

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield.
Independent licensees of the Blue Cross and Blue Shield Association