AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Triptans

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

7. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
8. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

Request for Non-Preferred Drug:

1. Failed two preferred drugs. List preferred drugs failed: _____
1a. __Allergic reaction 1b. __ Drug-to-drug interaction. Please describe reaction: _____
_____
2. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
_____
3. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
Please provide clinical information: _____
4. Age specific indications. Please give patient age and explain: _____
_____
5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____
6. Unacceptable clinical risk associated with therapeutic change. Please explain: _____
_____

Request for Exceeding Quantity Limit (Exceeding 12 per 30 days):

7. Does the beneficiary have a diagnosis of migraine or cluster headache? Yes___ No___
8. Does the beneficiary have more than 6 moderate or severe headaches? Yes___ No___
9. Does the beneficiary have a history of NSAID therapy in the past year? Yes___ No___
10. Does the beneficiary have a contraindication or allergy to NSAID therapy? Yes___ No___
11. Is the beneficiary currently receiving therapy with a migraine preventative? Yes___ No___
12. Does the beneficiary have a contraindication or history of an adverse reaction with preventative medications? Yes___ No___
Please list: _____
13. Did the beneficiary have no clinical benefit after at least a 90-day trial of preventative medications at the maximum tolerated dose? Yes___ No___
14. Has the beneficiary been diagnosed with Ischemic Heart Disease, Peripheral Vascular Disease, Cerebrovascular Disease, Ischemic Bowel Disease or Hemiplegic Migraine? Yes___ No___
15. Has the beneficiary received an MAO Inhibitor in the past 2 weeks? Yes___ No___
16. Will the beneficiary have concurrent use of (or use within 24 hours) ergotamine-containing or ergot-type medication? Yes___ No___
17. Will the beneficiary have concurrent use of (or use within 24 hours) another 5-HT1 agonist? Yes___ No___
18. Does the beneficiary have uncontrolled hypertension or basilar migraine? Yes___ No___
19. Has the prescriber reviewed the DHB evidenced-based recommendations on the treatment of migraine? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

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.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406