

Pharmacv NPI

Naratriptan

Iowa Department of Human Services

Request for Prior Authorization

FAX Completed Form To 1 (800) 574-2515

Provider Help Desk 1 (877) 776-1567

☐ Treximet*

SEROTONIN 5-HT1 RECEPTOR AGONISTS

(PLEASE PRINT – ACCURACY IS IMPORTANT) IA Medicaid Member ID # Patient name DOB Patient address Provider NPI Prescriber name Phone Prescriber address Fax Phone Pharmacy name Address

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy fax

☐ Zomig NS

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. Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. * Requests for non-preferred combination products may only be considered after documented separate trials and therapy failures with the individual ingredients. For consideration, the following information must be supplied: 1. The diagnosis requiring therapy, 2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications. Preferred (PA required after 12 doses in 30 days) Non- Preferred (PA required from Day 1)

☐ Almotriptan

NDC

☐ Imitrex Inj/NS/Tabs

 ☐ Rizatriptan ODT ☐ Rizatriptan Tablets ☐ Sumatriptan Inj ☐ Sumatriptan Nasal Spray ☐ Sumatriptan Tablets 	☐ Amerge☐ Axert☐ Eletriptan☐ Frova☐ Frovatriptan	☐ Maxalt☐ Maxalt MLT☐ Onzetra Xsail☐ Relpax☐ Sumatriptan-Naprox	☐ Zembrace ☐ Zolmitriptan ☐ Zomig Tablets ☐ Zomig ZMT
Strength	Dosage Instructions	Quantity	Days Supply
Diagnosis:			
different prophylactic medicatio	e current prophylactic therapy or 2 pons including drug names, strength, ex	act date ranges and failure r	easons:
Medical or contraindication reason	n to override trial requirements:		
Previous migraine therapy (includ	e drug/dose/duration):		
Reason for use of Non-Preferred	drug requiring prior approval:		
Other medical conditions to consider	der:		
Attach lab results and other do	cumentation 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. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.