



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586
 Worcester, MA 01613-2586

Fax: 1-877-208-7428 Phone: 1-800-745-7318

Triptan Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Amerge, Frova, Imitrex tablets and nasal spray, Maxalt, Maxalt-MLT, Relpax and Zomig nasal spray. **PA is not needed for Axert, Zomig, or Zomig-ZMT for quantity requests less than or equal to six units per month or for Imitrex injections for quantity requests less than or equal to two units (four injections) per month.**

Additional information about triptans can be found within the MassHealth Drug List at www.mass.gov/masshealth.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence <input type="checkbox"/> home <input type="checkbox"/> nursing facility					

Medication information

Triptan request	Quantity request	Dose, frequency, and duration of requested drug	Drug NDC (if known)
<input type="checkbox"/> Amerge tablet <input type="checkbox"/> Axert tablet <input type="checkbox"/> Frova tablet <input type="checkbox"/> Imitrex injection <input type="checkbox"/> Imitrex nasal spray <input type="checkbox"/> Imitrex tablet <input type="checkbox"/> Maxalt tablet <input type="checkbox"/> Maxalt-MLT tablet <input type="checkbox"/> Relpax tablet <input type="checkbox"/> Zomig nasal spray <input type="checkbox"/> Zomig tablet <input type="checkbox"/> Zomig-ZMT tablet <input type="checkbox"/> Other: _____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Indication for triptan requested (Check one.) <input type="checkbox"/> Acute treatment of migraine Frequency of migraine attacks (number/month) _____ Is member currently on migraine prophylaxis? <input type="checkbox"/> No. Explain why not. _____ <input type="checkbox"/> Yes. Specify agent(s), dose, and frequency. _____ _____ <input type="checkbox"/> Other. Specify pertinent medical history, diagnostic studies, and/or laboratory tests. _____ _____ Please attach supporting documentation (e.g., copies of medical records and/or office notes).	
Has member tried the following triptans: Axert and Zomig, or Zomig-ZMT? <input type="checkbox"/> Yes. Complete boxes A and B. <input type="checkbox"/> No. Explain why not. _____ _____ _____ _____		A. Dates of Axert use _____ Dose and frequency _____ Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other Briefly describe details of adverse reaction, inadequate response, or other. _____ _____ Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).	
Is the member under the care of a neurologist? <input type="checkbox"/> Yes. <input type="checkbox"/> No. Name of neurologist _____ Telephone No. _____ Date of last visit or consult _____		B. Dates of Zomig or Zomig-ZMT use _____ Dose and frequency _____ Did member experience any of the following? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other Briefly describe details of adverse reaction, inadequate response, or other. _____ _____ Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).	

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ()	Fax no. ()
Address		City	State Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State Zip
E-mail address			Telephone no. ()	Fax no. ()

Signature

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.

Prescriber's signature (Stamp not accepted.)

Date