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Serotonin E-HT1 Receptor Agonists Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk at 1-800-454-3730.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #:_____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____
7. Diagnosis: _____			

8. Approval criteria: Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

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 nonpreferred serotonin 5-HT1-receptor agonists as indicated on the *Iowa Medicaid Preferred Drug List* beginning the first day of therapy. Payment for nonpreferred 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 nonpreferred 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 requires 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)

Naratriptan
☐ Rizatriptan ODT
☐ Rizatriptan tablets
☐ Sumatriptan inj
☐ Sumatriptan nasal spray (NS)
☐ Sumatriptan tablets
☐ Zomig NS

Non- Preferred (PA required from Day 1)

☐ Almotriptan
☐ Amerge
☐ Axert
☐ Eletriptan
☐ Frova
☐ Frovatriptan
☐ Imitrex Inj/NS/tabs
☐ Maxalt
☐ Maxalt MLT
☐ Onzetra Xsail
☐ Relpax
☐ Sumatriptan-Naproxen*
☐ Tosymra
☐ Treximet*
☐ Zembrace
☐ Zolmitriptan
☐ Zomig tabs
☐ Zomig ZMT

If migraine, please **document the current prophylactic therapy or two previous trials and therapy failures with two different prophylactic medications** including drug names, strength, exact date ranges and failure reasons:

_____

_____

Medical or contraindication reason to override trial requirements: _____

Previous migraine therapy (include drug/dose/duration):_____

_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.