PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Triptans - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Triptans - Priority Partners MCO.

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.] \ [Note: Documentation must be submitted.]

[If no, then skip to question 3.]

2. Is the patient showing adequate response from treatment? Y N

[Note: Clinical documentation must be submitted.]

[No further questions.]

3.	Is this request for a non-formulary triptan?	Y N
	[If no, then skip to question 7.]	
4.	Has the patient tried and failed at least 2 formulary triptans?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	
5.	Is this request for dihydroergotamine (Migranal)?	Y N
	[If no, then skip to question 7.]	
6.	Will dihydroergotamine (Migranal) be used more frequently than 16 times per month?	Y N
	[If yes then no further questions.]	
7.	Is this request for a quantity greater than the Food and Drug Administration (FDA)-approved dosing?	Y N
	[If no, then no further questions.]	
8.	Is the requested drug being prescribed for migraine prophylaxis or chronic daily headache?	Y N
	[If yes, then no further questions.]	
9.	Is the patient undergoing an incremental dosage increase and the requested drug requires more than one tablet to achieve the prescribed dose?	Y N
	[If yes, then no further questions.]	
10.	Is the requested drug being prescribed for any of the following: A) Diagnosis of cluster headache, B) Treatment of intermittent, acute headache that requires repeat dosing to achieve relief, C) Diagnosis of migraine that requires frequent triptan use despite optimal therapy with prophylactic agent(s)?	Y N
	[Note: Documentation must be submitted.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date