Prior Authorization Request Form for
Migraine Agents: Oral Triptans

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient experienced an adverse reaction to, has had an inadequate response to, or has a medical contraindication to two different (that is, two different chemical entities) preferred oral/ODT triptan formulations of Relpax, rizatriptan, sumatriptan, or zolmitriptan that is not expected to occur with the non-preferred product (naratriptan, almotriptan, frovatriptan, or Treximet)?	☐ Yes Sign and date below	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[8 February 2017]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: