



Prior Authorization
JOHNS HOPKINS HEALTHCARE (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 Healthcare at 1-410-424-4607 . Please contact Johns Hopkins Healthcare 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: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Is this request for continuation of therapy?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Clinical documentation must be submitted.]	
[No further questions.]	

3. Is this request for a non-formulary triptan?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 7.]	
4. Has the patient tried and failed at least 2 formulary triptans?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
5. Is this request for dihydroergotamine (Migranal)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 7.]	
6. Will dihydroergotamine (Migranal) be used more frequently than 16 times per month?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes then no further questions.]	
7. Is this request for a quantity greater than the Food and Drug Administration (FDA)-approved dosing?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
8. Is the requested drug being prescribed for migraine prophylaxis or chronic daily headache?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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)?	<input type="checkbox"/> Y <input type="checkbox"/> 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