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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Zolmitriptan Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>
<p>Continuation of therapy: Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: (REQUIRED)</p> <hr/>

<p>Select the diagnosis below: <input type="checkbox"/> Migraine <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>

<p>Medication history: Has the patient had prior use of sumatriptan or is sumatriptan contraindicated, inappropriate, or ineffective for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Quantity Limit Requests: What is the quantity requested per MONTH? _____ What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____</p>

<p>For continuation of existing therapy, also answer the following: Would sudden discontinuation of the dose trigger withdrawal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No Would discontinuation of the dose be unsafe for the patient and their condition may worsen or exacerbate? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescribing provider attempting to taper or reduce the dose necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-855-297-2870.
 This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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