ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

# UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Complete this form in its entirety and send to Rocky Mountain Health Plans at 858-357-2538**

☐ **Urgent**[1] ☐ **Non-Urgent**

**Requested Drug Name: Triptans (anti-migraine) Maximum Quantity Override Request**

| **Patient Information:** | **Prescribing Provider Information:** |
|---|---|
| Patient Name: | Prescriber Name: |
| Member/Subscriber Number: | Prescriber Fax: |
| Policy/Group Number: | Prescriber Phone: |
| Patient Date of Birth (MM/DD/YYYY): | Prescriber Pager: |
| Patient Address: | Prescriber Address: |
| Patient Phone: | Prescriber Office Contact: |
| Patient Email Address: | Prescriber NPI: |
| | Prescriber DEA: |
| Prescription Date: | Prescriber Tax ID: |
| | Specialty/Facility Name (If applicable): |
| | Prescriber Email Address: |

**Prior Authorization Request for Drug Benefit:** ☐ New Request ☐ Reauthorization

Patient Diagnosis and ICD Diagnostic Code(s):

Drug(s) Requested (with J-Code, if applicable):

Strength/Route/Frequency:

Unit/Volume of Named Drug(s):

Start Date and Length of Therapy:

Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:

Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response:

## Triptans (anti-migraine) Maximum Quantity Override Request

**Triptans, as an abortive therapy, have a monthly limit of #12 tablets. Quantities beyond that must be *specified below,* submitted for prior authorization and appropriate medical necessity must be shown.**

**Clinical Consideration (for approval, please indicate and provide documentation of the following):**

Patient has failed recommended and reasonable Triptan regimen and requires more frequent dosing to achieve clinical benefit
☐ YES
☐ NO

Patient is currently on prophylactic therapy for migraine prevention
☐ YES
☐ NO

☐ Other (please state): _____

| | | | |
|---|---|---|---|
| | ☐ For use in clinical trial? (If yes, provide trial name and registration number): | | |
| | Drug Name (Brand Name and Scientific Name)/Strength: | | |
| | | | |
| | Dose: | Route: | Frequency: |
| | Quantity: | Number of Refills: | |
| | Product will be delivered to: ☐ Patient's Home ☐Physician Office | | Other: |
| | **Prescriber or Authorized Signature:** | | Date: |
| | Dispensing Pharmacy Name and Phone Number: | | |
| | | | |
| | ☐ **Approved** | ☐ **Denied** | |
| | If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier: | | |

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request