Triptans (Anti-migraine)
Maximum Quantity Override Request

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

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

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.

Complete the Clinical Assessment:

STEP 2

Clinical Consideration:	Patient has failed recommended and reasonable Triptan regimen and requires more frequent dosing to achieve clinical benefit ☐ YES ☐ NO	☐ Other (please state): _____
	Patient is currently on prophylactic therapy for migraine prevention ☐ YES ☐ NO	☐ Other (please state): _____
Supporting Documentation	Diagnosis: ICD-9/10 Code #/ Description / J code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Drug Name _____ Strength _____ Sig _____ Qty	
	Please indicate the maximum quantity per month you want this member to have:	
	Please attach all relevant medical records and test results **We will not process incomplete forms.** **If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.**	

I certify that the above is correct, accurate and complete to the best of my knowledge and further certify that this Triptan is not being used as prophylactic therapy. (please sign and date)

STEP 3

_____ _____
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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