FAX Completed Form To
1.877.386.4695
Provider Help Desk
1.866.399.0928

Request for Prior Authorization
SEROTONIN 5-HT1 RECEPTOR AGONISTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for quantities exceeding 12 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred agents. * Requests for non-preferred combination products may only be considered after documented separate trials and therapy failures with the individual ingredients. For consideration, the following information must be supplied: 1. The diagnosis requiring therapy. 2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

Preferred (PA required after 12 doses in 30 days)

- ☐ Naratriptan
- ☐ Rizatriptan ODT
- ☐ Rizatriptan Tablets
- ☐ Sumatriptan Inj
- ☐ Sumatriptan Nasal Spray
- ☐ Sumatriptan Tablets
- ☐ Zomig NS

Non- Preferred (PA required from Day 1)

- ☐ Almotriptan
- ☐ Amerge
- ☐ Axert
- ☐ Eletriptan
- ☐ Frova
- ☐ Frovatriptan
- ☐ Imitrex Inj/NS/Tabs
- ☐ Maxalt
- ☐ Maxalt MLT
- ☐ Onzetra Xsail
- ☐ Relpax
- ☐ Sumatriptan-Naproxen*
- ☐ Tosymra
- ☐ Treximet*
- ☐ Zembrace
- ☐ Zolmitriptan
- ☐ Zomig Tabs
- ☐ Zomig ZMT

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:_____

If Migraine, please **document the current prophylactic therapy or 2 previous trials and therapy failures with two different prophylactic medications** including drug names, strength, exact date ranges and failure reasons:

_____

_____

Medical or contraindication reason to override trial requirements: _____

Previous migraine therapy (include drug/dose/duration):_____

_____

Reason for use of Non-Preferred drug requiring prior approval:

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*