

**Triptan Quantity Limitation Request Form  
(Incomplete Forms May Delay Processing)**

PHYSICIAN NAME		PATIENT NAME	
OFFICE CONTACT PERSON		PATIENT INSURANCE ID #	
PHYSICIAN PHONE	PHYSICIAN FAX	PATIENT DATE OF BIRTH	
PHYSICIAN ADDRESS: Street		City	State Zip
Medication Requested: <input type="checkbox"/> Amerge® <input type="checkbox"/> Axert® <input type="checkbox"/> Frova® <input type="checkbox"/> Imitrex® <input type="checkbox"/> Maxalt® <input type="checkbox"/> Relpax® <input type="checkbox"/> Treximet™ <input type="checkbox"/> Zomig®			
Dosage form requested: _____ Strength requested: _____ Quantity requested per 30 days _____			
To request coverage of quantities greater than those listed on page two, please check all that are applicable.			
1. The patient has moderate to severe migraine headache with >4 episodes per month. (Headaches are not considered tension type, or chronic daily headaches.)		<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. The patient has tried and failed <b>at least 2 other abortive migraine therapies</b> . Examples of medications used for abortive therapy include:		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<ul style="list-style-type: none"> <li>• Ibuprofen (Motrin®)</li> <li>• Diclofenac (Voltaren®)</li> <li>• Flurbiprofen (Ansaid®)</li> <li>• Ergotamine containing products (Cafergot®, Wigraine®, Ergomar®, etc.)</li> <li>• Isometheptene mucate/Dichloralphenazone/Acetaminophen (Midrin®, etc.)</li> </ul>			
List names of medications tried: _____			
3. For patients experiencing >4 severe headaches per month, <b>prophylactic therapy</b> has been given an adequate trial.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
List names of medications tried: _____			
4. The possibility of medication-induced, rebound, or chronic daily headaches has been considered.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Will this drug be used in combination with another triptan or an ergot-containing medication?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. I am requesting Imitrex Injections for cluster headaches.		<input type="checkbox"/> YES	<input type="checkbox"/> NO
I certify that, to the best of my knowledge, the above information is accurate and is documented in the medical record:			
Physician signature required: _____			

**Please Return Completed Form To:** Fax number: 1-888-446-8535  
Address: BCBSNC

9/2008

Attention: Exceptions-Health Services  
P.O. Box 17509  
Winston-Salem, NC 27116-7509  
Provider telephone: 1-888-296-9790

**Triptan Quantity Limitation Request Form  
(Incomplete Forms May Delay Processing)**

<b><u>DRUG:</u></b>	<b><u>SHORT TERM:</u></b>	<b><u>EXTENDED SUPPLY:</u></b>
<b>AMERGE</b>	<b>23 mg per 30 days</b>	<b>69 mg per 90 days</b>
Amerge 2.5 mg	9 tablets	27 tablets
Amerge 1 mg	23 tablets	69 tablets
<b>AXERT</b>	<b>100 mg per 30 days</b>	<b>300 mg per 90 days</b>
Axert 6.25 mg	16 tablets	48 tablets
Axert 12.5 mg	8 tablets	24 tablets
<b>FROVA</b>	<b>30 mg per 30 days</b>	<b>90 mg per 90 days</b>
Frova 2.5 mg	12 tablets	36 tablets
<b>IMITREX</b>	<b>900 mg (tablet equivalent)* per 30 days</b>	<b>2700 mg (tablet equivalent)* per 90 days</b>
Imitrex tablets 100 mg	9 tablets	27 tablets
Imitrex tablets 50 mg	18 tablets	54 tablets
Imitrex tablets 25 mg	36 tablets	108 tablets
Imitrex injection kits/refills, 4 mg	4 kits (8 injections)	12 kits (24 injections)
Imitrex injection kits/refills, 6 mg	4 kits (8 injections)	12 kits (24 injections)
Imitrex nasal 20 mg	9 devices	27 devices
Imitrex nasal 5 mg	36 devices	108 devices
<b>MAXALT</b>	<b>120 mg per 30 days</b>	<b>360 mg per 90 days</b>
Maxalt 10 mg	12 tablets	36 tablets
Maxalt 5 mg	24 tablets	72 tablets
Maxalt MLT 10 mg	12 tablets	36 tablets
Maxalt MLT 5 mg	24 tablets	72 tablets
<b>RELPAK</b>	<b>320 mg per 30 days</b>	<b>960 mg per 90 days</b>
Relpax 20 mg	16 tablets	48 tablets
Relpax 40 mg	8 tablets	24 tablets
<b>TREXIMET</b>	<b>765 mg sumatriptan per 30 days</b>	<b>2295 mg sumatriptan per 90 days</b>
Treximet tablets	9 tablets	27 tablets
85 mg sumatriptan/500 mg naproxen sodium		
<b>ZOMIG</b>	<b>40 mg per 30 days</b>	<b>120 mg per 90 days</b>
Zomig ZMT 2.5 mg	16 tablets	48 tablets
Zomig ZMT 5 mg	8 tablets	24 tablets
Zomig tablets 2.5 mg	16 tablets	48 tablets
Zomig tablets 5 mg	8 tablets	24 tablets
Zomig 5 mg Nasal Spray	8 units	24 units

\* Tablet equivalents do not imply exact therapeutic equivalents. One injection ≈ 20 mg nasal spray ≈ 100 mg oral dosage. 5 mg nasal spray ≈ 25 mg tablet.

9/2008