

**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"/> 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. (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 at least 2 other abortive migraine therapies. Examples of medications used for abortive therapy include:		<input type="checkbox"/> YES <input type="checkbox"/> NO	
<ul style="list-style-type: none"> • Ibuprofen (Motrin®) • Diclofenac (Voltaren®) • Flurbiprofen (Ansaid®) • Ergotamine containing products (Cafergot®, Wigraine®, Ergomar®, etc.) • Isometheptene mucate/Dichloralphenazone/Acetaminophen (Midrin®, etc.) 			
List names of medications tried: _____			
3. For patients experiencing >4 severe headaches per month, prophylactic therapy 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:			
Physician signature required: _____			

Please Return Completed Form To: Fax number: 1-888-446-8535
 Address: BCBSNC
 Attention: Exceptions-Health Services
 P.O. Box 17509
 Winston-Salem, NC 27116-7509
 Provider telephone: 1-888-296-9790

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DRUG:	SHORT TERM:	EXTENDED SUPPLY:
AMERGE	23 mg per 30 days	69 mg per 90 days
Amerge 2.5 mg	9 tablets	27 tablets
Amerge 1 mg	23 tablets	69 tablets
AXERT	100 mg per 30 days	300 mg per 90 days
Axert 6.25 mg	16 tablets	48 tablets
Axert 12.5 mg	8 tablets	24 tablets
FROVA	30 mg per 30 days	90 mg per 90 days
Frova 2.5 mg	12 tablets	36 tablets
IMITREX	900 mg (tablet equivalent)* per 30 days	2700 mg (tablet equivalent)* per 90 days
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	3 kits (6 injections)	9 kits (18 injections)
Imitrex injection kits/refills, 6 mg	3 kits (6 injections)	9 kits (18 injections)
Imitrex injection vials, 6 mg	8 vials (8 injections)	24 vials (24 injections)
Imitrex nasal 20 mg	9 devices	27 devices
Imitrex nasal 5 mg	36 devices	108 devices
MAXALT	120 mg per 30 days	360 mg per 90 days
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
RELPAK	320 mg per 30 days	960 mg per 90 days
Relpax 20 mg	16 tablets	48 tablets
Relpax 40 mg	8 tablets	24 tablets
ZOMIG	40 mg per 30 days	120 mg per 90 days
Zomig ZMT 2.5 mg	16 tablets	48 tablets
Zomig ZMT 5 mg	9 tablets	27 tablets
Zomig tablets 2.5 mg	16 tablets	48 tablets
Zomig tablets 5 mg	9 tablets	27 tablets
Zomig 5 mg Nasal Spray	8 units	24 units

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

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