

# TRIPTAN QUANTITY LIMITATION FAX REQUEST FORM

## TO REQUEST COVERAGE OF QUANTITIES GREATER THAN THOSE LISTED ON PAGE TWO

Incomplete Forms May Delay Processing

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PRESCRIBER NAME	PROVIDER ID/TAX ID <small>(if out of state must have Tax ID)</small>	PATIENT NAME	
CONTACT PERSON		BCBSNC ID	
PRESCRIBER PHONE	PRESCRIBER FAX	DATE OF BIRTH	
PRESCRIBER ADDRESS	CITY	STATE	ZIP

Medication Requested:     Amerge®     Axert®     Frova®     Imitrex®  
     Maxalt®     Relpax®     Zomig®     Treximet®

Dosage form requested: \_\_\_\_\_ Strength requested: \_\_\_\_\_ Quantity requested per 30 days: \_\_\_\_\_

Number of headache days per month: \_\_\_\_\_ Practice specialty: \_\_\_\_\_

Please check all that are applicable:

- The patient has moderate to severe migraine headache with > 4 episodes per month. (Headaches are not considered tension type or chronic daily headaches.).....  Yes  No
- The patient has tried and failed at least 2 other abortive migraine therapies .....  Yes  No  
 Examples of medications used for abortive therapy include:
  - Ibuprofen (Motrin®)                      • Ergotamine containing products (Cafergot®, Wigraine®, Ergomar®, etc.)
  - Diclofenac (Voltaren®)                • Isometheptene mucate/Dichloralphenazone/Acetaminophen (Midrin®, etc.)
  - Flurbiprofen (Ansaid®)
 List names of medications tried: \_\_\_\_\_
- For patients experiencing > 4 migraines per month, prophylactic therapy has been given an adequate trial .....  Yes  No  
 List names of medications tried: \_\_\_\_\_
- The possibility of medication-induced, rebound, or chronic daily headaches has been considered .....  Yes  No
- This drug will be used in combination with another triptan or an ergot-containing medication .....  Yes  No
- I am requesting Imitrex Injections for cluster headaches .....  Yes  No  
**(Medical Records Necessary)**

I certify that the above information is accurate and **is documented in the medical record.**  
 Prescriber's Signature Required: \_\_\_\_\_ Date \_\_\_\_\_

**Fax completed form to 1-800-795-9403**

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# TRIPTAN QUANTITY LIMITATIONS

DRUG	SHORT TERM	EXTENDED SUPPLY
<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, 6 mg	4 kits (8 injections)	12 kits (24 injections)
Imitrex injection kits/refills, 4 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
* 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.		
<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>TREXIMET</b>	<b>765 mg sumatriptan* per 30 days</b>	<b>2295 mg sumatriptan* per 90 days</b>
Treximet tablets 85 mg with Naproxen 500 mg	9 tablets	27 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>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

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