



**TRIPTAN RESTRICTED-ACCESS CERTIFICATION AND
QUANTITY LIMITATION FAX REQUEST FORM**

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5 DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

MEDICATION REQUESTED: Sumatriptan (Imitrex® and generics for Imitrex only)
 Maxalt® or Maxalt MLT® Relpax® Naratriptan (Amerge®)

Yes NoAfter reviewing the Triptan Quantity Limitations table on page 3, will your patient require an amount of medication in excess of the quantity limit for the selected drug above? If yes, complete the questions on page 2 and fax both pages 1 and 2. If no, this form does not need to be submitted.

MEDICATION REQUESTED: Axert® Frova® Sumavel™DosePro™
 Treximet® Zomig® or Zomig ZMT® Alsuma™

The nonpreferred triptan medications listed above are classified as restricted-access drugs. Coverage for triptan medications will be limited to preferred agents sumatriptan (tablets, nasal spray, or injection), naratriptan (Amerge), Maxalt, Maxalt MLT, and Relpax unless written certification is provided by the physician stating that the patient meets the specific criteria listed in the signature box below.

DIAGNOSIS: _____

If you selected one of the restricted-access drugs above, please indicate which preferred drug(s) below have been tried: Sumatriptan (generic or brand Imitrex tablets, nasal spray, or injection)
 Maxalt, Maxalt MLT Relpax Naratriptan (Amerge)

Please certify the following by signing and dating below:

I certify that the above-referenced patient has previously used at least one of the preferred drugs in the pertinent drug class, as indicated above, and such drug was detrimental to the patient's health or was ineffective in treating the patient's condition and, in my opinion, is likely to be detrimental to the patient's health or ineffective in treating the condition again. I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

*Physician signature: _____ Date: _____

Yes NoAfter reviewing the Triptan Quantity Limitations table on page 3, will your patient require an amount of medication in excess of the quantity limit for the selected drug as listed in this table? If yes, complete the questions on page 2. If no, please complete page 1 and fax to 800-795-9403.

COMPLETE PAGE 2 TO REQUEST COVERAGE OF TRIPTAN QUANTITIES GREATER THAN THOSE LISTED ON PAGE 3

	<input type="checkbox"/> Naratriptan (Amerge®)	<input type="checkbox"/> Axert®	<input type="checkbox"/> Frova®
	<input type="checkbox"/> Maxalt®	<input type="checkbox"/> Sumatriptan (Imitrex®, Sumavel™ DosePro™, Alsuma™)	
Medication Requested:	<input type="checkbox"/> Relpax®	<input type="checkbox"/> Treximet®	<input type="checkbox"/> Zomig®
Dosage form requested: _____	Strength requested: _____	Quantity requested per 30 days: _____	
Number of headache days per month: _____		Practice specialty: _____	

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.)..... Yes No
2. The patient has tried and failed at least 2 other abortive migraine therapies..... Yes No
Examples of medication used for abortive therapy include:
 - Ibuprofen (Motrin®)
 - Diclofenac (Voltaren®)
 - Flurbiprofen (Ansaid®)
 - Ergotamine-containing products (Cafergot®, Ergomar®, etc)
 - Isometheptene/dichloralphenazone/acetaminophen (Midrin®, etc)*List names of medications tried:* _____
3. For patients experiencing > 4 migraines per month, prophylactic therapy has been given an adequate trial..... Yes No
List names of medications tried: _____
4. The possibility of medication-induced, rebound, or chronic daily headaches has been considered and ruled out or treated appropriately Yes No
5. This drug will be dosed concurrently with another triptan or an ergot-containing medication..... Yes No
6. I am requesting Imitrex (sumatriptan) injections, Alsuma, or Sumavel DosePro for cluster headaches..... Yes No
(Medical Records Necessary)

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

Fax completed form (pages 1 and 2) to 1-800-795-9403

TRIPTAN QUANTITY LIMITATIONS

<u>DRUG:</u>	<u>SHORT TERM:</u>	<u>EXTENDED SUPPLY:</u>
NARATRIPTAN (AMERGE)	23 mg per 30 days	69 mg per 90 days
Amerge/naratriptan 2.5 mg	9 tablets	27 tablets
Amerge/naratriptan 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
SUMATRIPTAN / IMITREX / SUMAVEL DOSEPRO / ALSUMA	900 mg (tablet equivalent)* per 30 days	2700 mg (tablet equivalent)* per 90 days
Imitrex/sumatriptan tabs 100 mg	9 tablets	27 tablets
mitrex/sumatriptan tabs 50 mg	18 tablets	54 tablets
Imitrex/sumatriptan tabs 25 mg	36 tablets	108 tablets
Imitrex/sumatriptan injection kits/refills, 6 mg	4 kits (8 injections)	12 kits (24 injections)
Imitrex/sumatriptan injection kits/refills, 4 mg	4 kits (8 injections)	12 kits (24 injections)
Imitrex/sumatriptan nasal 20 mg	9 devices	27 devices
Imitrex/sumatriptan nasal 5 mg	36 devices	108 devices
Sumavel DosePro system 6 mg	8 systems	24 systems
Alsuma injection 6 mg	8 injections	24 injections
* 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.		
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
TREXIMET	765 mg sumatriptan per 30 days	2295 mg sumatriptan per 90 days
Treximet tablets 85 mg sumatriptan/500 mg naproxen sodium	9 tablets	27 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	8 tablets	24 tablets
Zomig tablets 2.5 mg	16 tablets	48 tablets
Zomig tablets 5 mg	8 tablets	24 tablets
Zomig nasal spray 5 mg	8 units	24 units