PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Sumatriptan (nasal spray and injection)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Sumatriptan 5 mg nasal spray
- ☐ Sumatriptan 20 mg nasal spray
- ☐ Sumatriptan 4 mg injection
- ☐ Sumatriptan 6 mg injection

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have documentation of migraine induced vomiting; AND
2. Must have failed or be intolerant to at least one formulary preferred triptan tablet (i.e. sumatriptan tablet, naratriptan tablet, rizatriptan tablet); AND
3. Must have failed or be intolerant to at least one formulary preferred triptan orally disintegrating tablet (rizatriptan ODT tablet); AND
4. Must be age 18 years and older.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Migraine induced vomiting
- ☐ Migraine without vomiting
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 03/2018
Last reviewed 05/2019

B. What medications have the patient previously trialed for their migraines?

Drug & dose: _____ Dates: _____ Outcome: _____
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Additional information

Note: The quantity of sumatriptan nasal spray is limited to 1 package with 6 doses per 30 days. The quantity of sumatriptan injection is limited to 4 mL per 30 days.

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