UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for

Triptans

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

Request for Non-Preferred Drug:

1. Failed two preferred drug(s). List preferred drugs failed: _____
   1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction: _____
2. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
   _____
   _____
3. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
4. Age specific indications. Please give patient age and explain: _____
5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference:
   _____
6. Unacceptable clinical risk associated with therapeutic change. Please explain: _____
   _____

Request for Exceeding Quantity Limit (Exceeding 12 per 30 days):

7. Does the patient have a diagnosis of migraine or cluster headache? ☐ **Yes** ☐ **No**
8. Does the patient have more than 6 moderate or severe headache? ☐ **Yes** ☐ **No**
9. Does the patient have a history of NSAID therapy in the past year? ☐ **Yes** ☐ **No**
10. Does the patient have a contraindication or allergy to NSAID therapy? ☐ **Yes** ☐ **No**
11. Is the patient currently receiving therapy with a migraine preventative? ☐ **Yes** ☐ **No**
12. Does the patient have a contraindication or history of an adverse reaction with preventative medications? ☐ **Yes** ☐ **No**
    Please list: _____
13. Did the patient have no clinical benefit after at least a 90 day trial of preventative medications at the maximum tolerated dose? ☐ **Yes** ☐ **No**
14. Has the patient been diagnosed with Ischemic Heart Disease, Peripheral Vascular Disease, Cerebrovascular Disease, Ischemic Bowel Disease, or Hemiplegic Migraine? ☐ **Yes** ☐ **No**
15. Has the patient received an MAO Inhibitor in the past 2 weeks? ☐ **Yes** ☐ **No**
16. Will the beneficiary have concurrent use of (or use within 24 hours) ergotamine-containing or ergot-type medication? ☐ **Yes** ☐ **No**
17. Will the beneficiary have concurrent use of (or use within 24 hours) another 5- HT1 agonist? ☐ **Yes** ☐ **No**
18. Does the patient have uncontrolled hypertension or basilar migraine? ☐ **Yes** ☐ **No**
19. Has the prescriber reviewed the DHB evidenced-based recommendations on the treatment of migraine? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593