

OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION REQUEST FORM*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7516 or 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.

Drug Name: Frova® (frovatriptan), Axert® (almotriptan), Amerge® (naratriptan), Maxalt® (rizatriptan), Zomig® (zolmitriptan), Imitrex® (brand)

Drug Requested (pick one):

- Frova®
- Axert®
- Amerge®
- Maxalt®
- Maxalt-MLT®
- Zomig®
- Imitrex® (for brand)
- Treximet®

Reason for Request (at least one of the following criteria must be met):

- Patient has tried and failed therapy with sumatriptan
- Patient has tried and failed therapy with sumatriptan AND Relpax® (for members with a **closed** formulary)
- Patient enrolled with Optima Health within the past three months and was stable on Frova®, Axert®, Amerge®, Maxalt®, or Zomig® prior to enrollment (subject to verification by Optima Health)

Patient Name _____

Member Number _____

Physician Signature _____

Date _____

Physician Name _____ Phone Number _____

Fax Number _____

Pharmacy Name _____ Pharmacy Tel # _____