Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Triptans

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. 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: _____
   a. Was the failure due to an allergic reaction? ☐ **Yes** ☐ **No**
   b. Was the failure due to a drug-to-drug interaction? ☐ **Yes** ☐ **No**
   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 member circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
4. Age specific indications. Please give member 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 member have a diagnosis of migraine or cluster headache? ☐ **Yes** ☐ **No**
8. Does the member have more than 6 moderate or severe headache? ☐ **Yes** ☐ **No**
9. Does the member have a history of NSAID therapy in the past year? ☐ **Yes** ☐ **No**
10. Does the member have a contraindication or allergy to NSAID therapy? ☐ **Yes** ☐ **No**
11. Is the member currently receiving therapy with a migraine preventative? ☐ **Yes** ☐ **No**
12. Does the member have a contraindication or history of an adverse reaction with preventative medications? ☐ **Yes** ☐ **No** Please list: _____
13. Did the member have no clinical benefit after at least a 90 day trial of preventative medications at the maximum tolerated dose? ☐ **Yes** ☐ **No**
14. Has the member been diagnosed with Ischemic Heart Disease, Peripheral Vascular Disease, Cerebrovascular Disease, Ischemic Bowel Disease, or Hemiplegic Migraine? ☐ **Yes** ☐ **No**
15. Has the member 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 member 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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277