



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
 P.O. Box 2586, Worcester, MA 01613-2586  
**Fax:** 1-877-208-7428      **Phone:** 1-800-745-7318

## Headache Therapy (Triptan) Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at [www.mass.gov/druglist](http://www.mass.gov/druglist).

### Member information

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
 MassHealth member ID # \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Gender (Check one.)  F  M      Member's place of residence  home  nursing facility

### Medication information

#### Medication requested

- |   |  |
|---|--|
| <input type="checkbox"/> almotriptan  | <input type="checkbox"/> sumatriptan nasal spray                   |
| <input type="checkbox"/> eletriptan   | <input type="checkbox"/> sumatriptan tablet > quantity limits      |
| <input type="checkbox"/> frovatriptan   | <input type="checkbox"/> sumatriptan/naproxen                      |
| <input type="checkbox"/> naratriptan  | <input type="checkbox"/> Sumavel                                   |
| <input type="checkbox"/> Onzetra  | <input type="checkbox"/> Zembrace                                  |
| <input type="checkbox"/> rizatriptan orally disintegrating tablet > quantity limits | <input type="checkbox"/> zolmitriptan orally disintegrating tablet |
| <input type="checkbox"/> rizatriptan tablet > quantity limits                       | <input type="checkbox"/> zolmitriptan tablet                       |
| <input type="checkbox"/> sumatriptan injection                                      | <input type="checkbox"/> Zomig nasal spray                         |
| <input type="checkbox"/> Other* _____   |  |

*\*If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

**Quantity requested per month** \_\_\_\_\_

**Dose, frequency, and duration of requested drug** \_\_\_\_\_

#### Indication (Check all that apply.)

- Cluster headache. Frequency of headaches (number/month) \_\_\_\_\_
- Migraine headache. Frequency of migraine attacks (number/month) \_\_\_\_\_
- Other. Specify pertinent medical history, diagnostic studies, and/or laboratory tests. \_\_\_\_\_

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**Section I. Please complete for all requests, excluding generic rizatriptan orally disintegrating tablet, rizatriptan tablets and sumatriptan tablets. Please note, this section must be completed for brand name Imitrex tablet, Maxalt MLT, or Maxalt tablet requests.**

1. Has the member tried sumatriptan tablets?

Yes. Please describe the outcome.  inadequate response  adverse reaction  
Briefly describe the details of inadequate response or adverse reaction.

\_\_\_\_\_  
 No. Explain why sumatriptan tablets are not appropriate for this member.

2. Has the member tried rizatriptan?

Yes. Please describe the outcome.  inadequate response  adverse reaction  
Briefly describe the details of inadequate response or adverse reaction.

\_\_\_\_\_  
 No. Explain why rizatriptan is not appropriate for this member.

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**Section II. Please complete for requests for quantities above quantity limits.**

1. Is the member under the care of a neurologist?  Yes  No

2. Is the member currently receiving prophylaxis?

Yes. Please specify.

Drug \_\_\_\_\_ Dose and frequency \_\_\_\_\_

Drug \_\_\_\_\_ Dose and frequency \_\_\_\_\_

No. Explain why prophylaxis is not appropriate for this member.

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**Section III. Please complete for requests for Onzetra, sumatriptan injection, sumatriptan nasal spray, Sumavel, Zembrace, Zomig nasal spray and zolmitriptan orally disintegrating tablets.**

1. Please describe medical necessity for the use of the requested dosage formulation over tablet formulation.

2. For Onzetra requests, has the member had a trial with sumatriptan nasal spray?

Yes. Please describe the outcome.  inadequate response  adverse reaction  
Briefly describe the details of inadequate response or adverse reaction.

\_\_\_\_\_  
 No. Explain why sumatriptan nasal spray is not appropriate for this member.

3. For Zembrace requests, has the member had a trial with sumatriptan injection?

Yes. Please describe the outcome.  inadequate response  adverse reaction  
Briefly describe the details of inadequate response or adverse reaction.

\_\_\_\_\_  
 No. Explain why sumatriptan injection is not appropriate in this member.

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**Section IV. Please complete for requests for sumatriptan/naproxen.**

1. Has the member had a trial with sumatriptan used in combination with naproxen?  
 Yes. Please describe the outcome.  inadequate response  adverse reaction  
Briefly describe the details of inadequate response or adverse reaction.

No. Explain why sumatriptan in combination with naproxen is not appropriate for this member.

2. Please describe medical necessity for the use of the fixed-dose combination (sumatriptan/naproxen) over the individual components.
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**Section V. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.**

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

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**Prescriber information**

Last name\* \_\_\_\_\_ First name\* \_\_\_\_\_ MI \_\_\_\_\_  
NPI\* \_\_\_\_\_ Individual MH Provider ID \_\_\_\_\_  
DEA No. \_\_\_\_\_ Office Contact Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Telephone No.\* \_\_\_\_\_ Fax No.\* \_\_\_\_\_

\* *Required*

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**Prescribing provider's attestation, signature, and date**

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

**Signature required** \_\_\_\_\_

Printed name of prescribing provider \_\_\_\_\_ Date \_\_\_\_\_