US Family Health Plan
Prior Authorization Request Form for
Migraine Agents: Oral Triptans

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Has the patient experienced an adverse reaction to, has had an inadequate response to, or has a medical contraindication to two different (that is, two different chemical entities) preferred oral/ODT triptan formulations of Relpax, rizatriptan, sumatriptan, or zolmitriptan that is not expected to occur with the non-preferred product (naratriptan, almotriptan, frovatriptan, or Treximet)?	☐ Yes Sign and date below	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[8 February 2017]