



# Migraine Prior Authorization Request

Fax the completed form to (816) 271-1228  
or mail to 137 North Belt Highway, St. Joseph, MO 64506.

Questions? Call (816) 271-4019 or (800) 447-5819.

**Quantities below allowed *without* prior authorization**

Drug Name	Qty. Limit per Month	Box Equivalent	Drug Name	Qty. Limit per Month	Box Equivalent
Amerge®	9	1 box	Maxalt®	18	2 boxes
Axert™	12	2 boxes	Maxalt – MLT®	18	2 boxes
Frova™	18	2 boxes	Relpax®	12	2 boxes
Imitrex® Injection	8 injections	4 boxes	Zomig® 2.5mg	12	2 boxes
Imitrex® Nasal Spray	6 sprays	1 box	Zomig® 5mg	12	4 boxes
Imitrex® Tablets	18	2 boxes	Zomig – ZMT™ 2.5mg	12	2 boxes
			Zomig – ZMT™ 5mg	12	4 boxes

**Provider Information**

Prescriber's Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Name: \_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_ CHP Member ID: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Female  Male

Has the member seen a neurologist?  Yes  No

Neurologist Results: \_\_\_\_\_

Tests performed (MRI, CAT Scan, etc.)? \_\_\_\_\_

Test results: \_\_\_\_\_

Prophylactic medications tried: \_\_\_\_\_

Which proved beneficial? \_\_\_\_\_

Which drug(s) failed and what was the outcome? \_\_\_\_\_

**How many migraine headaches/month does member experience?**

- less than 4 per month     3 – 4 per month     1 – 2 per month     less than 1 per month

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