Maryland Pharmacy Program

Anti-migraine (Triptans)
Maximum Quantity Override Request

18473

Request Date / /

PATIENT INFORMATION

Patient's Medicaid ID Number

Patient's Date of Birth / /

Patient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City **State** **Zip Code** -

Prescriber Phone: - -

Prescriber Fax: - -

DEA# -

Drug Requested:

Strength _____ **Quantity Per Month** _____

Please check all that apply:

○ **Yes** ○ **No** **1. Patient has failed recommended regimen and requires more frequent dosing to receive clinical benefits of drug.**

○ **Yes** ○ **No** **2. Is patient on migraine prophylaxis therapy or failed prophylaxis therapy?**

Non-preferred drugs require separate preauthorization. Maximum Quantity Limits

Brand Name	Dosage Form	How Supplied	Units Per Month
	PREFERRED DRUGS		
Imitrex®	Tablets	9 Tablets/Pkg	9 Tablets
Imitrex®	Injection	2 Injections/Pkg	2 Injections
Imitrex®	Nasal Spray	6 Units/Pkg	6 Units
Maxalt®	Tablets	12 Tablets/Pkg	12 Tablets
Maxalt® MLT	Orally Disintegrating Tablets	3 Units of 3/Pkg	9 Tablets
Relpax®	Tablets	2 Units of 3/Pkg	12 Tablets
	NON-PREFERRED DRUGS		
Amerge®	Tablets	9 Tablets/Pkg	9 Tablets
Axert®	Tablets	6 Tablets/Pkg	6 Tablets
Frova®	Tablets	9 Tablets/Pkg	9 Tablets
Treximet®	Tablets	9 Tablet/Pkg	9 Tablets
Zomig® 2.5 mg	Tablets	6 Tablets/Pkg	6 Tablets
Zomig® 5 mg	Tablets	3 Tablets/Pkg	6 Tablets
Zomig®	Nasal Spray	6 Units/Pkg	6 Units
Zomig® 2.5 mg	Orally Disintegrating Tablets	6 Tablets/Pkg	6 Tablets
Zomig® 5 mg	Orally Disintegrating Tablets	3 Tablets/Pkg	6 Tablets

I certify that patient is not using Triptans for prophylaxis and that this request is not for duplicate therapy nor mutiple strengths of the same medication.

Date / /

Signature of Prescriber_____

FAX TO: Maryland Pharmacy Program

Fax: (866) 440 - 9345

PA HELPDESK: (800)932-3918

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Revised - March 11, 2009