



18473

Maryland Pharmacy Program
Anti-migraine (Triptans)
Maximum Quantity Override Request

Request Date

Request date input fields: MM / DD / YYYY

Patient's Medicaid ID Number PATIENT INFORMATION

Patient's Medicaid ID Number input fields

Patient's Date of Birth

Patient's Date of Birth input fields: MM / DD / YYYY

Patient's Full Name

Patient's Full Name input fields

Prescriber's Full Name PRESCRIBER INFORMATION

Prescriber's Full Name input fields

Prescriber Street Address

Prescriber Street Address input fields

City

City input fields

State

State input fields

Zip Code

Zip Code input fields: XXXXX - XXXXX

Prescriber Phone:

Prescriber Phone input fields: XXX-XXX-XXXX

Prescriber Fax:

Prescriber Fax input fields: XXX-XXX-XXXX

DEA#

DEA# input fields: XX-XXXXXXX

Drug Requested:

Drug Requested input fields

Strength _____ Quantity Per Month _____

Please check all that apply:

- 1. Patient has failed recommended regimen and requires more frequent dosing to receive clinical benefits of drug.
2. Is patient on migraine prophylaxis therapy or failed prophylaxis therapy?

Non-preferred drugs require separate preauthorization. Maximum Quantity Limits

Table with 4 columns: Brand Name, Dosage Form, How Supplied, Units Per Month. Lists preferred and non-preferred drugs like sumatriptan, Maxalt, Relpax, Amerge, Axert, Frova, Treximet, Zomig.

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

Date

Date input fields: MM / DD / YYYY

Signature of Prescriber

FAX TO: Maryland Pharmacy Program
Fax: (866) 440 - 9345
PA HELPDESK: (800)932-3918

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