



Symbravo® Prior Authorization Request Form

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Member Information (required)

Provider Information (required)

Member Name:	Provider Name:		
Insurance ID#:	NPI#:	Specialty:	
Date of Birth:	Office Phone:		
Street Address:	Office Fax:		
City:	State:	Zip:	Office Street Address:
Phone:	City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Select the diagnosis below:

Acute treatment of migraine with or without aura
 Other diagnosis _____

ICD-10 Code(s): _____

Clinical information:

The physician attests that the requested medication is medically necessary. Document rationale for use:

Has the patient tried serotonin (5-HT) receptor agonists (triptans)? Yes No

If yes, which one(s)? _____

How long has the patient tried the above listed medications? _____

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

Titration or loading dose purposes
 Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
 Requested strength/dose is not commercially available
 Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

For urgent or expedited requests please call 1-855-401-4262.

This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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