Prior Authorization Form

Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Butorphanol NS Post Limit (Medicare Prior Auth)
This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **1-888-836-0730**.
Please contact CVS|Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Butorphanol NS Post Limit (Medicare Prior Auth).

Drug Name (select from list of drugs shown)
Butorphanol NS

Patient Information
Patient Name: ______________________________
Patient ID: ______________________________
Patient Group No.: ______________________________
Patient DOB: ______________________________

Prescribing Physician
Physician Name: ______________________________
Physician Phone: ______________________________
Physician Fax: ______________________________
Physician Address: ______________________________
City, State, Zip: ______________________________

Diagnosis: ______________________ ICD Code: ______________________

Please circle the appropriate answer for each applicable question.

1. Does the patient have the diagnosis of moderate to severe migraine headache? Y N
2. Has the patient been evaluated for medication-induced, stress, cluster, and chronic daily headaches? Y N
3. Has the patient had a trial of abortive migraine therapy agents (examples include: triptans [such as Amerge, Axert, Frova, Imitrex, Maxalt, Relpax, Treximet, or Zomig], ergot derivatives [such as Cafergot, D.H.E., or Migranal] and NSAIDs)? Y N
4. Has the patient been unresponsive to all abortive migraine agents? Y N
5. Has the patient been considered for prophylactic therapy (examples include: beta blockers [such as propranolol, atenolol, or metoprolol], tricyclic antidepressants [such as amitriptyline or imipramine], calcium channel blockers [such as nifedipine, verapamil, or diltiazem], and antiepileptics [such as sodium valproate, topiramate, or gabapentin])? Y N
6. Is the use of this opioid analgesic appropriate? Y N
7. Has the patient had trials of multiple oral analgesic alternatives Y N

(examples include: morphine products, oxycodone products, codeine products, hydrocodone products)?

[If the answer to this question is no, skip to question 9.]

8. Did the patient have a documented inadequate response or adverse reaction to multiple oral analgesic alternatives? Y N

[If the answer to this question is yes, then no further questions are required.]

9. Is the patient unable to take oral medications, including liquids? Y N

Comments: ____________________

I affirm that the information given on this form is true and accurate as of this date.

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Prescriber (Or Authorized) Signature and Date