



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)  
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)  
Imitrex Inj 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 Imitrex Inj Post Limit (Medicare Prior Auth).

**Drug Name (select from list of drugs shown)**

Imitrex Injectable Kit (sumatriptan)

Imitrex Injection 12mg/ml (sumatriptan)

**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 a diagnosis of migraine headache?<br>[If the answer to this question is yes, skip to question 3.]   | Y | N |
| 2. Does the patient have the diagnosis of cluster headache?<br>[If the answer to this question is yes, skip to question 7.]  | Y | N |
| 3. Does the patient experience more than four migraine headaches per month?<br>[No authorization is required for a quantity sufficient to treat four or fewer headaches per month.]  | Y | N |
| 4. Is the patient currently using migraine prophylactic therapy?<br>[Examples include: amitriptyline, Depakote, fluoxetine, nadolol, propranolol, sodium valproate, timolol, topiramate, verapamil.]<br>[If the answer to this question is yes, skip to question 6.] | Y | N |
| 5. Has the patient failed or been intolerant to at least 2 different migraine prophylactic therapies, or are all migraine prophylactic therapies contraindicated for the patient?  | Y | N |
| 6. Given the potential for medication overuse headache when triptan drugs are used with increased frequency, has the possibility that the patient is experiencing medication overuse headache been considered and ruled out?   | Y | N |



# Arkansas BlueCross BlueShield

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|--|---|---|
| 7. Is the patient taking this medication in combination with another triptan (Amerge, Axert, Frova, Imitrex, Maxalt, Relpax, Treximet, or Zomig) or an ergotamine-containing drug (examples include: Migranal, DHE, Cafergot)? | Y | N |
| 8. Does the patient have confirmed or suspected cardiovascular or cerebrovascular disease or uncontrolled hypertension?  | Y | N |

**Comments:** \_\_\_\_\_

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

\_\_\_\_\_  
**Prescriber (Or Authorized) Signature and Date**