



Prior Authorization Form

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

Drug Name (select from list of drugs shown)

Imitrex Tablet (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? | Y | N |
| 2. Does the patient experience more than four migraine headaches per month?
[No authorization is required for a quantity sufficient to treat four or fewer headaches per month.] | Y | N |
| 3. Is the patient currently using migraine prophylactic therapy?
[Examples include: amitriptyline, Depakote, fluoxetine, nadolol, propranolol, sodium valproate, timolol, topiramate, verapamil.]
[If the answer to this question is yes, skip to question 5.] | Y | N |
| 4. 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 |
| 5. 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 |
| 6. 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: | Y | N |



**Arkansas
BlueCross BlueShield**

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Migranal, DHE, Cafegot)?

7. 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