



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Treximet Post Limit (Medicare Prior Authorization)**

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 Treximet Post Limit (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)

Treximet

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 migraine headache? | Y | N |
| 2. Does the patient experience more than three to four migraine headaches per month? | Y | N |
| 3. Is the physician aware that prophylactic therapy should be considered if the patient experiences three or more migraine headaches per month? | Y | N |
| 4. Has prophylactic therapy been considered? | Y | N |
| 5. Is the physician aware of the rebound headache potential with the increased frequency of use with the triptan drugs? | Y | N |
| 6. Has the possibility of medication-induced, rebound, or chronic daily headache been considered? | Y | N |
| 7. Is the patient taking this medication in combination with another triptan (e.g., Zomig, Maxalt, Imitrex) or an ergotamine-containing drug product (e.g., Migranal, DHE, Cafergot)? | Y | N |
| 8. Does the patient have a history of ischemic or vasospastic coronary artery disease (CAD)? | Y | N |
| 9. Does the patient have any of the following risk factors strongly predictive of CAD: Hypertension, hypercholesterolemia, smoker, | Y | N |



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obesity, diabetes, strong family history of CAD, female with surgical or physiological menopause, male over 40?

10. Has the physician done an evaluation of the patient that confirms cardiovascular disease does not exist? 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