CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Prior Authorization Form

CAREFIRST

Amerge, Imitrex, Maxalt, Zomig Post Limit

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 Amerge, Imitrex, Maxalt, Zomig Post Limit.

Drug Name (specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

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

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Does the patient have confirmed or suspected cardiovascular or cerebrovascular disease, or uncontrolled hypertension?	Y N
2.	Does the patient have a diagnosis of migraine headache?	Y N
	[If no, then skip to question 5.]	
3.	Is the patient currently using migraine prophylactic therapy or unable to take migraine prophylactic therapies due to inadequate response, intolerance or contraindication?	Y N
	[Note: examples of prophylactic therapy are divalproex sodium, topiramate, valproate sodium, metoprolol, propranolol, timolol, atenolol, nadolol, amitriptyline, venlafaxine.]	
4.	Has medication overuse headache been considered and ruled out?	Y N
	[If yes, then skip to question 7.]	
	[If no, then no further questions.]	

5.	Does the patient have a diagnosis of cluster headache?	Y N
6.	Is the request for Alsuma, Imitrex (sumatriptan) Injection, Imitrex (sumatriptan) Nasal Spray, Sumavel DosePro, or Zomig Nasal Spray?	Y N
7.	Is the patient treating more than eight headaches per month with a 5-HT1 agonist?	Y N

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

Prescriber (Or Authorized) Signature and Date