PA Request Criteria

88809

12/05/2014

Prior Authorization Criteria Form

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 888-836-0730. Please contact CVS/caremark at 888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Drug Name (specify drug) _____

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name:

Patient Phone: - -

Patient ID:

Patient Group No:

Patient DOB: / /

Prescribing Physician

Physician Name:

Physician Phone: - -

Physician Fax: - -

Physician Address:

City, State, Zip:

Diagnosis: _____ **ICD Code:**

Comments: _____

_____

_____

Please check the appropriate answer for each applicable 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** ☐

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[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** ☐

   [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** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

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Prescriber (Or Authorized) Signature and Date