

BUTORPHANOL NS

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

- Does the patient have the diagnosis of moderate to severe migraine headache? Y N
- Has the patient been evaluated for medication-induced, stress, cluster or chronic daily headaches? Y N
- Has the patient had a trial of abortive migraine therapy agents (examples include: triptans [such as Treximet, Axert, Amerge, Maxalt, Imitrex, Frova, Zomig or Relpax], ergot derivatives [such as Cafergot, D.H.E. or Migranal] and NSAIDs)? Y N
- Has the patient been unresponsive to all abortive migraine agents? Y N
- Has the patient been considered for prophylactic therapy (examples include: beta blockers [such as propranolol, atenolol or metoprolol], tricyclic antidepressants [such as amitriptyline or imipramine], calcium channel blockers [such as nifedipine, verapamil or diltiazem] and antiepileptics [such as sodium valproate, topiramate or gabapentin])? Y N

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6. Is the use of this opioid analgesic appropriate? Y N
7. Has the patient had a trial of multiple oral analgesic alternatives (examples include: morphine products, oxycodone products, codeine products, hydrocodone products)? Y N
[If the answer to this question is no, skip to question 9.]
8. Did the patient have a documented inadequate response or adverse reaction to multiple oral analgesic alternatives? Y N
[If the answer to this question is yes, then no further questions are required.]
9. Is the patient unable to take oral medications, including liquids? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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