

SUMATRIPTAN INJECTABLE (POST LIMIT)

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

Patient Information	
Name:	Insurance ID #:
Address:	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 800-294-5979 with any questions concerning prior authorization procedures.

- Does the patient have the diagnosis of migraine headaches?
[If the answer to this question is yes, skip to question 3.] Y N
- Does the patient have the diagnosis of cluster headaches?
[If the answer to this question is yes, skip to question 7.] Y N
- 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
- Is the patient currently using migraine prophylactic therapy?
[Examples include: amitriptyline, Depakote, fluoxetine, nadolol, propranolol, sodium valproate, timolol, topiramate and verapamil.]
[If the answer to this question is yes, skip to question 6.] Y N
- Has the patient failed or been intolerant to at least two different migraine prophylactic therapies, or are all migraine prophylactic therapies contraindicated for the patient? Y N
- 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
- 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: Migranal, DHE, Cafergot)? Y N

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8. Does the patient have confirmed or suspected cardiovascular or cerebrovascular disease or uncontrolled hypertension?

 Y N

Comments: _____

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

Prescriber's Signature:	Date:
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