

RELPAK (POST LIMIT) (MEDICARE PRIOR AUTHORIZATION)

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 completed, please fax to Caremark at 888-836-0730.

This fax machine is located 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.

When conditions are met, we will authorize the coverage of Relpax Post Limit (Medicare Prior Auth)

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

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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, Cafegot)? 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, obesity, diabetes, strong family history of CAD, female with surgical or physiological menopause, male over 40? Y N
10. Has the physician done an evaluation of the patient that confirms cardiovascular disease does not exist? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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