CareFirst BlueCross BlueShield
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Prior Authorization Form

CAREFIRST

Relpax 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 Relpax Post Limit.

Drug Name (select from list of drugs shown)
Relpax (eletriptan)

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