



The CareFirst BlueCross BlueShield family of health care plans



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? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 2. Does the patient have a diagnosis of migraine headache? | <input type="checkbox"/> Y <input type="checkbox"/> 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? | <input type="checkbox"/> Y <input type="checkbox"/> 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? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| [If yes, then skip to question 7.] | |
| [If no, then no further questions.] | |
| 5. Does the patient have a diagnosis of cluster headache? | <input type="checkbox"/> Y <input type="checkbox"/> N |

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6. Is the request for Alsuma, Imitrex (sumatriptan) Injection, Imitrex (sumatriptan) Nasal Spray, Sumavel DosePro, or Zomig Nasal Spray?	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Is the patient treating more than eight headaches per month with a 5-HT1 agonist?	<input type="checkbox"/> Y <input type="checkbox"/> N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date