BlueCross BlueShield Federal Employee Program®

5-HT1 AGONISTS (TRIPTANS) PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

NOTE: Form must be completed in its **entirety** for processing

Please select medication and indicate quantity per 90 days:

Injection Kits
- ❑**Imitrex 4mg/0.5ml (sumatriptan)** qty _____ per 90 days
- ❑**Imitrex 6mg/0.5ml (sumatriptan)** qty _____ per 90 days

Injection Syringes
- ❑**Zembrace 3mg (sumatriptan)** qty _____ per 90 days

Injection Vials
- ❑**Imitrex 6mg/0.5ml (sumatriptan)** qty _____ per 90 days

Nasal Powder Kits
- ❑**Onzetra Xsail 11mg (sumatriptan)** qty _____ per 90 days

Nasal Sprays
- ❑**Imitrex 5mg (sumatriptan)** qty _____ per 90 days
- ❑**Imitrex 20mg (sumatriptan)** qty _____ per 90 days
- ❑**Tosymra 10mg (sumatriptan)** qty _____ per 90 days
- ❑**Zomig 2.5mg (zolmitriptan)** qty _____ per 90 days
- ❑**Zomig 5mg (zolmitriptan)** qty _____ per 90 days

Tablets
- ❑**Almotriptan 6.25mg** qty _____ per 90 days
- ❑**Almotriptan 12.5mg** qty _____ per 90 days
- ❑**Amerge 1mg (naratriptan)** qty _____ per 90 days
- ❑**Amerge 2.5mg (naratriptan)** qty _____ per 90 days
- ❑**Frova 2.5mg (frovatriptan)** qty _____ per 90 days
- ❑**Imitrex 25mg (sumatriptan)** qty _____ per 90 days
- ❑**Imitrex 50mg (sumatriptan)** qty _____ per 90 days
- ❑**Imitrex 100mg (sumatriptan)** qty _____ per 90 days
- ❑**Relpax 20mg (eletriptan)** qty _____ per 90 days
- ❑**Relpax 40mg (eletriptan)** qty _____ per 90 days
- ❑**Treximet (sumatriptan)** qty _____ per 90 days
- ❑**Zomig 2.5mg (zolmitriptan)** qty _____ per 90 days
- ❑**Zomig 5mg (zolmitriptan)** qty _____ per 90 days

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?
   - ❑Cluster headache
   - ❑Migraine, with aura (classic)
   - ❑Migraine, without aura (common)
   - ❑Other diagnosis ***(please specify)***: _____
2. **Imitrex Injection or Zembrace Request**: Is Imitrex injection or Zembrace being used for acute treatment of cluster headache? ❑Yes ❑No
3. Has the patient been on this medication continuously for the last **4 months**, excluding samples? ❑Yes ❑No*
   If NO, is the patient currently using migraine prophylactic therapy (e.g., divalproex sodium, topiramate, valproate sodium, metoprolol, propranolol, etc.)? ❑Yes ❑No*
   If NO, does the patient have an intolerance or contraindication or have they had inadequate treatment response to migraine prophylactic therapy? ❑Yes ❑No
4. Does the patient also have a diagnosis of basilar or hemiplegic migraines? ❑Yes ❑No
5. Is the patient currently using a calcitonin gene related peptide (CGRP) antagonist for **ACUTE** migraine treatment, such as Nurtec ODT or Ubrelvy? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

6. Will this medication be used in combination with Elyxyb (celecoxib) or Reyvow (lasmiditan)? ❑Yes ❑No

7. **Patient Age 6 to 11**: Has this medication been prescribed by a neurologist? ❑Yes ❑No

8. Will this medication be used in combination with other triptan medications? ❑Yes***** ❑No
   ****If YES***, specify medication(s) and quantity needed for a 90 day supply: _____

_____

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.