BlueCross BlueShield
Federal Employee Program.

# MAXALT
# PRIOR APPROVAL REQUEST

**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**

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.

| **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** | | | | | |

**The Service Benefit Plan does NOT require a Prior Approval (PA) request for a standard allowance. Standard allowance for 5mg is 72 tablets and 10mg is 36 tablets per 90 days for patients age 18 or older. PA is required ONLY in requests that EXCEED the standard allowance.**

## Maxalt / Maxalt-MLT

**(rizatriptan)**

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

**Please select strength:** ❑ **5mg** ❑ **5mg (MLT)** ❑ **10mg** ❑ **10mg (MLT)**

****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. Does the patient have a diagnosis of migraine with aura (classic) or migraine without aura (common)? ❑Yes* ❑No
   ***If YES***, please select one of the following: ❑Migraine, with aura (classic) **OR** ❑Migraine, without aura (common)
2. Does the patient also have a diagnosis of basilar or hemiplegic migraines? ❑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 an inadequate treatment response to migraine prophylactic therapy? ❑Yes ❑No
4. Is the patient currently using a calcitonin gene related peptide (CGRP) antagonist, such as Nurtec ODT or Ubrelvy, for acute migraine treatment? ❑Yes ❑No
5. Will this medication be used in combination with Elyxyb (celecoxib) or Reyvow (lasmiditan)? ❑Yes ❑No
6. 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: _____
   _____
7. **Age 6-17**: Please answer the following questions:
   a. Is the patient currently on propranolol? ❑Yes ❑No
   b. What is the patient's weight? _____ kg **OR** _____ lbs
   c. How many tablets (plain and/or MLT) will the patient need for a 90 day supply? _____ tablet(s) per 90 days
8. **Age 18 or older:** Please select strength and provide quantity:
   a. Please **indicate specific number** of quantities required for a **3 month** period:
   ❑5mg ⇨ **72 tabs (standard allowance)** + _____ additional tabs/90 days = _____ (total # of 5mg tabs)
   ❑10mg ⇨ **36 tabs (standard allowance)** + _____ additional tabs/90 days = _____ (total # of 10mg tabs)

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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.*** |