



Federal Employee Program.

5-HT1 AGONISTS (TRIPTRANS)
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) and Provider Information (required) form with fields for Date, Patient Name, Date of Birth, Sex, Street Address, City, State, Zip, Patient ID, Provider Name, Specialty, NPI, Office Phone, Office Fax, Office Street Address, City, State, Zip, Physician Signature.

NOTE: Form must be completed in its entirety for processing

Please select medication and indicate quantity per 90 days:

Medication selection table with columns for Injection Kits, Nasal Powder Kits, Nasal Sprays, and Tablets, listing various drugs like Imitrex, Zomig, and Almotriptan with checkboxes and quantity fields.

\*\*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, Migraine without aura, Other diagnosis.
2. Imitrex Injection or Zembrace Request: Is Imitrex injection or Zembrace being used for acute treatment of cluster headache?
3. Has the patient been on this medication continuously for the last 4 months, excluding samples?
4. Does the patient also have a diagnosis of basilar or hemiplegic migraines?
5. Is the patient currently using a calcitonin gene related peptide (CGRP) antagonist for ACUTE migraine treatment, such as Nurtec ODT or Ubrelvy?

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS



**BlueCross  
BlueShield**

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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: \_\_\_\_\_

Message:

Attached is a Prior Authorization request form.

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

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| <p><b>Electronically Online</b><br/>(ePA)<br/>Results in 2-3 minutes<br/><b>FASTEST AND EASIEST</b></p> | <p>Now you can get responses to drug Prior Authorization requests <b>securely</b> online. <b>Online</b> submissions may receive <b>instant</b> responses and do not require faxing or phone calls.<br/>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 <b>Caremark.com/ePA.</b></p>                            |
| <p><b>Phone</b><br/>(4-5 minutes for response)</p>  | <p>The FEP Clinical Call Center can be reached at <b>(877)-727-3784</b> 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.<br/>The process over the phone takes on average between 4 and 5 minutes.</p> |
| <p><b>Fax</b><br/>(3-5 days for response)</p>   | <p>Fax the attached form to <b>(877)-378-4727</b>. 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.<br/><b><u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></b></p>                |

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| <p><b>faster...<br/>easier...<br/>better...</b></p> | <p>Introducing ePA! Online Prior Authorizations in minutes through <b>Caremark.com/ePA</b>. Sign up today!</p> <p><b>CVS/caremark</b> </p> |
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