Prior Authorization Criteria Form

CVS/CAREMARK FAX FORM

Amerge, Imitrex, Maxalt, Zomig 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 **1-888-414-3125** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Amerge, Imitrex, Maxalt, Zomig Post Limit.

Drug Name (select from list of drugs shown)

Amerge (naratriptan)	Imitrex Tablet (sumatriptan)	Maxalt (rizatriptan)
Maxalt MLT (rizatriptan)	Zomig (zolmitriptan)	Zomig ZMT (zolmitriptan)

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each applicable question.

1. Does the member have a diagnosis of migraine headache? Y N
2. Does the member experience more than four migraine headaches per month? Y N
   [No authorization is required for a quantity sufficient to treat four or fewer headaches per month.]
3. Is the member currently using migraine prophylactic therapy (e.g., amitriptyline, divalproex sodium, propranolol, timolol)? Y N
   [If the answer to this question is yes, skip to question 6.]
4. Has the member experienced an inadequate treatment response or intolerance to at least 2 different migraine prophylactic therapies? Y N
   [If the answer to this question is yes, skip to question 6.]
5. Does the member have a contraindication to all migraine prophylactic therapies? Y N
6. Given the potential for medication overuse headache when triptan drugs are used with increased frequency, has the possibility that the member is experiencing medication overuse headache been considered and ruled out? Y N
7. Is the member taking this medication in combination with another triptan (e.g., Alsuma, Amerge, Axert, Frova, Imitrex, Maxalt, Relpax, Sumavel, Treximet, or Zomig) or an ergotamine- Y N

containing drug (e.g., Migranal, Cafergot)?

8. Does the member have confirmed or suspected cardiovascular or cerebrovascular disease, or uncontrolled hypertension? Y N

Comments: _____

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

_____

Prescriber (Or Authorized) Signature and Date