Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Frova 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 Frova Post Limit.

Drug Name (select from list of drugs shown)

Frova (frovatriptan) Frovatriptan Tablets

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?	Y N
2.	Does the patient have a diagnosis of migraine headache?	Y 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?	Y 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?	Y N
	[If yes, then skip to question 6.]	
5.	Is the request for sumatriptan injection, sumatriptan nasal spray, or zolmitriptan nasal spray, (Imitrex Inj, Imitrex NS, Sumavel DosePro, Zomig NS) for the treatment of cluster headache?	Y N
6.	The plan provides coverage up to an amount sufficient for treating eight headaches per month at the maximum daily dose of the prescribed drug. Does the patient need an amount for treating more than eight headaches per month with a 5-HT1 agonist?	Y N

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

Prescriber (Or Authorized) Signature and Date