Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Headache Agents (FA-PA)

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 **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Headache Agents (FA-PA).

Drug Name (select from list of drugs shown)

| | | |
|---|---|---|
| Butalbital-APAP-Caffeine Capsule | Cafergot (ergotamine-caffeine) | Capacet (butalbital-APAP-caffeine) |
| Esgic Capsule (butalbital-APAP-caffeine) | Fioricet (butalbital-APAP-caffeine) | Zebutal (butalbital-APAP-caffeine) |

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. The patient's drug benefit plan provides coverage for other drugs which may be considered for treating your patient. Can your patient's treatment be switched to a formulary drug? [If yes, provide your patient with a new prescription for the preferred product.] Y N

Available Formulary Alternatives: eletriptan, ergotamine-caffeine, naratriptan, rizatriptan, sumatriptan, zolmitriptan, ONZETRA XSAIL, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY

| | | |
|---|---|---|
| 2. | Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? | Y N |
| | | |
| 3. | Does the prescribed dose and quantity fall within the FDA approved labeling or within dosing guidelines found in the compendia of current literature? | Y N |
| 4. | Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below [If yes, then documentation is required for approval.] Drug Name and Reason for Failure | Y N |
| | Note: Formulary Alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Required Formulary Alternatives: 3 in a class with 3 or more alternatives, eletriptan, ergotamine-caffeine, naratriptan, rizatriptan, sumatriptan, zolmitriptan, ONZETRA XSAIL, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY | |
| | [If yes, no further questions.] | |
| 5. | Does the patient have a contraindication to all the alternatives? | Y N |

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

| |
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| **Prescriber (Or Authorized) Signature and Date** |