Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION
Stadol Nasal Spray 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 Stadol Nasal Spray Post Limit.

Drug Name (select from list of drugs shown)

 Butorphanol Nasal Spray   Stadol (butorphanol) Nasal Spray

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 a diagnosis of migraine headache?	Y N
2. Has medication overuse headache been ruled out?	Y N
3. Is the patient unable to take abortive migraine therapy due to inadequate treatment response, intolerance, or contraindication?	Y N
[Note: examples of abortive therapy are triptans, ergotamine, dihydroergotamine, NSAIDs, mixed analgesics containing caffeine, isometheptene, or butalbital]	
4. Is the patient currently using migraine prophylactic therapy or unable to take migraine prophylactic therapies due to	Y N

inadequate treatment response, intolerance or contraindication?		
[Note: examples of prophylactic therapy are divalproex sodium, topiramate, valproate sodium, metoprolol, propranolol, timolol, atenolol, nadolol, amitriptyline, venlafaxine.]		
5. Has the patient experienced an inadequate treatment response, intolerance, or contraindication to at least two oral opioids?	Y N	
[If yes, then skip to question 7.]		
6. Is the patient unable to take oral medications, including liquids?	Y N	
7. Is this request for more than 4 bottles per month?	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