Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Zembrace SymTouch 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 Zembrace SymTouch Post Limit.

Drug Name (select from list of drugs shown)
Zembrace SymTouch 3mg/0.5mL Inj. (sumatriptan)

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