Prior Authorization Form

CAREFIRST

Treximet 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 Treximet Post Limit.

Drug Name (select from list of drugs shown)
Treximet (sumatriptan/naproxen sodium)

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 7.]	
	[If no, then no further questions.]	

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5.	Does the patient have a diagnosis of cluster headache?	Y N
6.	Is the request for Alsuma, Imitrex (sumatriptan) Injection, Imitrex (sumatriptan) Nasal Spray, Sumavel DosePro, or Zomig Nasal Spray?	Y N
7.	Is the patient 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