MIGRAINE AGENTS QUANTITY LIMIT REQUEST

PRESCRIBER FAX FORM

ONLY the provider may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Patient Name (First): Last: M: DOB (mm/ddlypyy): Patient Address: City, State, Zip Patient Telephone: BCBSTX ID Number: Group Number: RESCRIBER/CLINIC INFORMATION Breacher State Prescriber NPI#: Specialty: Contact Name: Clinic Name: Clinic Address: City, State, Zip: Phone #: Secure Fax #: LEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST Patient's Diagnosis - ICD code plus description: Medication Requested: Strength: Dosing Schedule: Quantity per Month: 1. Is the patient currently treated with the requested medication? Yes No If yes, when was treatment with the requested medication setated? Yes No If wo, please provide reason: Yes No If wo, please provide reason: Yes No If wo, please provide reason: Yes No I. Strength: Yes No If yes, it leasons for selecting the requested medication, overuse headache? Yes No If yes, it leasons for selecting the requested medication, dosing schedule, and quantity over alter	Incomplete forms will be re formulary information	and to dov	wnload add				com/pro	vider/m	edicaid/rx_prior_aut			
Patient Address: City, State, Zip Patient Telephone: BCBSTX ID Number: Group Number: Group Number: BCSCRIERCLINC INFORMATION Prescriber NPI#: Specialty: Contact Name: Clinic Name: Clinic Address: Clinic Address: City, State, Zip: Phone #: Secure Fax #: LEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST Patient's Diagnosis - ICD code plus description: Medication Requested: Strength: Dosing Schedule: Quantity per Month: 1. Is the patient currently treated with the requested medication? Yes 2. Is the patient currently prescribed prophylactic migraine medication? Yes 3. Has the patient been evaluated for medication overuse headache? Yes 3. Has the patient been found that patient does have medication overuse headache? Yes No If yes, sha it been found that patient does have medication overuse headache? Yes No 9. Please list all other medications the patient is currently taking for treatment of this diagnosis: Yes No 9. Please list all other medications the patient is currently taking for treatment of this diagnosis: Pate(s): Date(s): Date(s): Date(s): Date(PATIENT AND INSURANCE INFORMATION Patient Name (First): Last:								Today's Date: M: DOB (mm/dd/yyyy):			
BCBSTX ID Number: Group Number: RESCRIBER/CLINIC INFORMATION Prescriber Name: Cinic Address: Clinic Name: Clinic Address: Clinic Address: City, State, Zip: Phone #: Secure Fax #: LEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST Patient's Diagnosis - ICD code plus description: Medication Requested: Strength: Dosing Schedule: Quantity per Month: 1. Is the patient currently treated with the requested medication started? Yes No If yes, when was treatment with the requested medication started? Yes No If no, please provide reason: Yes No I. Is the patient currently prescribed prophylactic migraine medication overuse headache? Yes No If yes, has it been found that patient does have medication overuse headache? Yes No If yes, has it been found that patient does have medication overuse headache? Yes No If yes, has it been found that patient does have medication dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives. Iower dose tried):												
RESCRIBER/CLINIC INFORMATION Prescriber NPI#: Specially: Contact Name: Clinic Name: Clinic Address: Clinic Address: City, State, Zip: Phone #: Secure Fax #: LEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST Patient's Diagnosis - ICD code plus description: Medication Requested: Strength: Dosing Schedule: Quantity per Month: 1. Is the patient currently treated with the requested medication started? Yes 2. Is the patient currently prescribed prophylactic migraine medication overuse headache? Yes No If no, please provide reason: Yes No No 4. Will the patient been evaluated for medication overuse headache? Yes No 4. Will the patient been evaluated for medication overuse headache? Yes No 6. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried):	Patient Address: City, State, 2				p							
Prescriber Name: Prescriber NPI#: Specialty: Contact Name: Clinic Name: Clinic Address: City, State, Zip: Phone #: Secure Fax #: LEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST Patient's Diagnosis - ICD code plus description: Medication Requested: Strength: Dosing Schedule: Quantity per Month: 1 Is the patient currently treated with the requested medication started? 2: Is the patient currently rescribed prophylactic migraine medication? Yes No If yes, when was treatment with the requested medication overuse headache? Yes No If no, please provide reason: Yes No If yes, has it been found that patient does have medication overuse headache? Yes No If yes, has it been found that patient does have medication overuse headache? Yes No 9. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried):	BCBSTX ID Number:					Group Number:						
Clinic Name: Clinic Address: City, State, Zip: Phone #: Secure Fax #: LEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST Patient's Diagnosis - ICD code plus description: Medication Requested: Strength: Dosing Schedule: Quantity per Month: 1. Is the patient currently treated with the requested medication started? Yes 2. Is the patient currently prescribed prophylactic migraine medication? Yes No If no, please provide reason: Yes No I. yes, has it been found that patient does have medication overuse headache? Yes No I. yes, has it been found that patient does have medication overuse headache? Yes No I. yes, has it been found that patient does have medication overuse headache? Yes No Please list all reasons for selecting the requested medication, with another acute migraine SHT agent (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried):	RESCRIBER/CLINIC INFO	RMATION	N									
City, State, Zip: Phone #: Secure Fax #: LEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST Patient's Diagnosis - ICD code plus description: Medication Requested: Strength: Dosing Schedule: Quantity per Month: 1 Is the patient currently treated with the requested medication? Quantity per Month: 1. Is the patient currently prescribed prophylactic migraine medication? Yes No If no, please provide reason: Yes No If yes, has it been found that patient does have medication overuse headache? Yes No If yes, has it been found that patient does have medication overuse headache? Yes No 4. Will the patient be using the requested agent in combination with another acute migraine 5HT agent Yes No 5. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried):	Prescriber Name: Prescriber NPI#:			er NPI#:	Specialty:				Contact Name:			
LEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST Patient's Diagnosis - ICD code plus description: Medication Requested: Strength: Dosing Schedule: Quantity per Month: 1. Is the patient currently treated with the requested medication? Yes No If yes, when was treatment with the requested medication? Yes No If no, please provide reason: Yes No 3. Has the patient been evaluated for medication overuse headache? Yes No H yes, has it been found that patient does have medication overuse headache? Yes No 4. Will the patient be using the requested agent in combination with another acute migraine 5HT agent Yes No 5. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried):	Clinic Name:				Clinic	Address:						
Patient's Diagnosis - ICD code plus description: Medication Requested: Strength: Dosing Schedule: Quantity per Month: 1. Is the patient currently treated with the requested medication? Yes 2. Is the patient currently prescribed prophylactic migraine medication? Yes 2. Is the patient currently prescribed prophylactic migraine medication? Yes 3. Has the patient been evaluated for medication overuse headache? Yes 3. Has the patient been evaluated for medication overuse headache? Yes 4. Will the patient be using the requested agent in combination with another acute migraine 5HT agent (e.g., triptan, 5HT-1F, ergotamine)? Yes No 5. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): Yes No 6. Please list all medications the patient is currently taking for treatment of this diagnosis. (Please specify if the patie(s): Date(s): Date(s): Prov Authorized Signature: Date(s): Date(s): Date(s): Date(s): Contraindication of a treating physician. Only treation of deemsits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only treating physician. Only treating physician. Only treatin	City, State, Zip:				Phone #: S			ecure Fax #:				
Medication Requested: Strength: Dosing Schedule: Quantity per Month: 1. Is the patient currently treated with the requested medication? Yes 1. Is the patient currently prescribed prophylactic migraine medication started? Yes 2. Is the patient currently prescribed prophylactic migraine medication? Yes 3. Has the patient been evaluated for medication overuse headache? Yes 3. Has the patient been evaluated for medication overuse headache? Yes 4. Will the patient be using the requested agent in combination with another acute migraine 5HT agent (e.g., triptan, 5HT-1F, ergotamine)? 5. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): 6. Please list all other medications the patient is currently taking for treatment of this diagnosis: Date(s): 7. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products). Date(s): Prox Authorized Signature: Date(s): Date(s): Prof Authorized Signature: Date(s): Date(s): Prof Authorized Signature: Contraind physician can determine what medications are appropriete for a patient. Ple	LEASE ATTACH ANY ADD	ITIONAL	. INFORM	ATION THAT	SHOUL	D BE CONSIDER		тн тн	S REQUEST			
Dosing Schedule: Quantity per Month: 1. Is the patient currently treated with the requested medication? Pres 2. Is the patient currently prescribed prophylactic migraine medication? Pres 2. Is the patient currently prescribed prophylactic migraine medication? Pres 3. Has the patient been evaluated for medication overuse headache? Pres 3. Has the patient been evaluated for medication overuse headache? Pres 4. Will the patient be using the requested agent in combination with another acute migraine 5HT agent Pres (e.g., triptan, 5HT-1F, ergotamine)? Yes No 5. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): Prescriber or Authorized Signature: 7. Please list all medications the patient is currently taking for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products). Date(s): Date(s): Date(s): Date(s): Date(s):	Patient's Diagnosis - ICD co	de plus d	escription	:								
1. Is the patient currently treated with the requested medication? Yes No If yes, when was treatment with the requested medication started? Yes No If no, please provide reason: Yes No If no, please provide reason: Yes No If yes, has it been found that patient does have medication overuse headache? Yes No If yes, has it been found that patient does have medication overuse headache? Yes No 4. Will the patient be using the requested agent in combination with another acute migraine 5HT agent (e.g., triptan, 5HT-1F, ergotamine)? Yes No 5. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): Yes No 6. Please list all medications the patient is currently taking for treatment of this diagnosis: Date(s): Date(s):	Medication Requested:					Streng	gth:					
If yes, when was treatment with the requested medication started? 2. Is the patient currently prescribed prophylactic migraine medication? 2. Is the patient currently prescribed prophylactic migraine medication? 3. Has the patient been evaluated for medication overuse headache? 3. Has the patient been evaluated for medication overuse headache? 4. Will the patient be using the requested agent in combination with another acute migraine 5HT agent (e.g., triptan, 5HT-1F, ergotamine)? 2. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): 2. Please list all other medications the patient is currently taking for treatment of this diagnosis: 2. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products). 2. Date(s): Date(s): 2. Date(s): Date(s): 2. Prescriber or Authorized Signature: Date(s): 2. Prescriber or aut	Dosing Schedule:					Quan	tity per	Month:				
If yes, when was treatment with the requested medication started? Is the patient currently prescribed prophylactic migraine medication? Is the patient currently prescribed prophylactic migraine medication? If no, please provide reason: Image: the patient been evaluated for medication overuse headache? Image: the patient been evaluated for medication overuse headache? Image: the patient been evaluated for medication overuse headache? Image: the patient been evaluated for medication overuse headache? Image: the patient been evaluated for medication overuse headache? Image: the patient be using the requested agent in combination with another acute migraine 5HT agent (e.g., triptan, 5HT-1F, ergotamine)? Image: the patient has previously the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): Image: the patient has tried brand-name products, generic products, or over-the-counter products). Image: the patient has tried brand-name products, generic products, or over-the-counter products). Image: the patient beard for the patient of the substitute for the independent medical judgment of a treating physician. Only treating physician and determine what medications. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the heathet of the patient. Prescriber o	1. Is the patient currently t	reated wi	th the req	uested medicat	ion?				🗌 Yes	□ No		
2. Is the patient currently prescribed prophylactic migraine medication? Yes No If no, please provide reason: Yes No 3. Has the patient been evaluated for medication overuse headache? Yes No if yes, has it been found that patient does have medication overuse headache? Yes No 4. Will the patient be using the requested agent in combination with another acute migraine 5HT agent Yes No (e.g., triptan, 5HT-1F, ergotamine)? Yes No 5. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): Yes No 5. Please list all other medications the patient is currently taking for treatment of this diagnosis: Date(s): Date(s): Date(s): Date(s): Date(s): Date(s): Date(s): Date(s): Date(s): Date(s): Prior Authorization of Benefits is not the practice of medications. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Vete: Payment is subject to member eligibility Authorization does not guarantee payment. Constileer of this communication is intended only for the of the indegend mater.										_		
If no, please provide reason:	-			-						□ No		
If yes, has it been found that patient does have medication overuse headache? Image: Share in the state in the stat				-								
If yes, has it been found that patient does have medication overuse headache? Image: No 4. Will the patient be using the requested agent in combination with another acute migraine 5HT agent Image: No (e.g., triptan, 5HT-1F, ergotamine)? Image: No 5. Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): Image: No 6. Please list all other medications the patient is currently taking for treatment of this diagnosis: Image: No 7. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products). Image: Date(s): Image: Date(s												
Will the patient be using the requested agent in combination with another acute migraine 5HT agent (e.g., triptan, 5HT-1F, ergotamine)? Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): 6. Please list all other medications the patient is currently taking for treatment of this diagnosis: 7. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products).	3. Has the patient been ev	aluated for	or medica	tion overuse he	eadache	e?			🗌 Yes	🗌 No		
(e.g., triptan, 5HT-1F, ergotamine)? Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): 6. Please list all other medications the patient is currently taking for treatment of this diagnosis: 7. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products).	If yes, has it been t	ound that	t patient d	oes have medi	cation c	overuse headache	?		🗌 Yes	🗌 No		
Please list all reasons for selecting the requested medication, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): Please list all other medications the patient is currently taking for treatment of this diagnosis: Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products). Date(s):			-				-	-				
contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried):		•										
6. Please list all other medications the patient is currently taking for treatment of this diagnosis:						-	-	-				
7. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products).								ineu).				
patient has tried brand-name products, generic products, or over-the-counter products). Date(s):	6. Please list all other med	lications t	he patient	t is currently ta	iking fo	or treatment of this	diagno	osis:				
patient has tried brand-name products, generic products, or over-the-counter products). Date(s):	7 Please list all medicatio	ns the nat	tient has r	previously trie	d and f	ailed for treatmen	t of this	diado	nsis (Please sper	cify if the		
Date(s): Dateatetatas datetatas datetatas datetatas datetatas datetatas datetas		•	-					alagin				
Date(s): Dateatetatas datetatas datetatas datetatas datetatas datetatas datetas			Date	e(s):	_				Date(s): _			
Prescriber or Authorized Signature: Date: Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility Authorization does not guarantee payment. Please fax or mail this form to: Prime Therapeutics LLC, Clinical Review Department 2900 Ames Crossing Road Eagan, Minnesota 55121 CONFIDENTIALITY NOTICE: This communication is intended only for the individual entity to which it is addressed and may contain information is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication is error, please notify the sender immediately by telephone at 66.202.3474 and return the original message to Prime Therapeutics via U.			Date	e(s):	_				Date(s): _			
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility Authorization does not guarantee payment. Please fax or mail this form to: Prime Therapeutics LLC, Clinical Review Department 2900 Ames Crossing Road Eagan, Minnesota 55121 CONFIDENTIALITY NOTICE: This communication is intended only for the individual entity to which it is addressed and may contain information is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copies of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone a66.202.3474 and return the original message to Prime Therapeutics via U.			Date		_				Date(s): _			
reating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility Authorization does not guarantee payment. Please fax or mail this form to: Prime Therapeutics LLC, Clinical Review Department 2900 Ames Crossing Road Eagan, Minnesota 55121 CONFIDENTIALITY NOTICE: This communication is intended only for the individual entity to which it is addressed and may contain information is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or cop of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone a66.202.3474 and return the original message to Prime Therapeutics via U.					Ibstitute	for the independent				sician Only a		
complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility Authorization does not guarantee payment. Please fax or mail this form to: Prime Therapeutics LLC, Clinical Review Department 2900 Ames Crossing Road Eagan, Minnesota 55121 FOLL FREE Concerned Construction is strictly prohibited. If you have received this communication is error, please notify the sender immediately by telephone a66.202.3474 and return the original message to Prime Therapeutics via U.	reating physician can determin	e what me	dications a	re appropriate foi	r a patiel	nt. Please refer to th	e applica	able pla	n for the detailed inf	formation		
Please fax or mail this form to: Prime Therapeutics LLC, Clinical Review Department 2900 Ames Crossing Road Eagan, Minnesota 55121 FOLL FREE CONFIDENTIALITY NOTICE: This communication is intended only for the individual entity to which it is addressed and may contain information is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone a66.202.3474 and return the original message to Prime Therapeutics via U.	complete and the requested se	rvices are i	medically ir	ndicated and nec	essary to	o the health of the pa				ato, ana		
Prime Therapeutics LLC, Clinical Review Department 2900 Ames Crossing Road Eagan, Minnesota 55121 TOLL FREE TOLL FREE TOL FR	, ,	0			0	1 3	: This c	ommun	ication is intended of	only for the use		
Eagan, Minnesota 55121 recipient, you are hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone 866.202.3474 and return the original message to Prime Therapeutics via U.		al Review I	Departmen	t c	of the inc	dividual entity to which	ch it is ad	ddresse	d and may contain i	information that		
roll FREE of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone 866.202.3474 and return the original message to Prime Therapeutics via U.												
866.202.3474 and return the original message to Prime Therapeutics via U.	-				of this co	mmunication is stric ication in error, pleas	tly prohi se notify	bited. If the ser	you have received to oder immediately by	this telephone at		
		Phone: 84	55.457 04						ge to Prime Therape	utics via U.S.		