CVS/caremark

Prior Authorization Form

CAREFIRST

Frova 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 Frova Post Limit.

Drug Name (select from list of drugs shown)
Frova (frovatriptan)

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