TRIPTANS DHE AGENTS PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

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

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/rx-prior-auth

Patient Address: City, State, Zip: Patient Telephone:	PATIENT AND INSURANCE INFORMATION Today's Date:							
BCBSTX ID Number: PRESCRIBER/CLINIC INFORMATION Prescriber Name: Clinic Name: Clinic Address:	Patient Name (First):							
Prescriber Name: Clinic Name: Clinic Address:	Patient Address:	City, State, Zip:				Patient Telephone:		
Prescriber Name: Prescriber NPI#: Specialty: Contact Name:	BCBSTX ID Number:				Group Number:	•		
Prescriber Name: Prescriber NPI#: Specialty: Contact Name:	PRESCRIBER/CLINIC INFORMATI	ON						
City, State, Zip: Phone #: Secure Fax #: Patient's Diagnosis-ICD code plus description: Medication Requested: Your request will be reviewed for the generic equivalent unless you specify brand is required. Dosing Schedule: 1. Is the patient currently treated with the requested agent?					Specialty:		Contact Name:	
Patent's Diagnosis-ICD code plus description: Medication Requested: Strength: "Your request will be reviewed for the generic equivalent unless you specify brand is required. Dosing Schedule: 1. Is the patient currently treated with the requested agent?	Clinic Name: Clinic Address:							
Redication Requested: Strength: Strength: Your request will be reviewed for the generic equivalent unless you specify brand is required. Dosing Schedule: Quantity per Month: Is the patient currently treated with the requested agent? Yes No If yes, when was treatment with the requested agent started? Step agent expected with a migraine prophylactic agent? If yes, please document agents: If no, please provide reason: Yes No No No No No No No N	City, State, Zip:			Phone	hone #:		Secure Fax #:	
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Tour request will be reviewed for the generic equivalent unless you specify brand is required.	Patient's Diagnosis-ICD code plus							
1. Is the patient currently treated with the requested agent?								
If yes, when was treatment with the requested agent started?	Dosing Schedule: Quantity per Month:							
2. Is the patient currently being treated with a migraine prophylactic agent? If yes, please document agents: If no, please provide reason: 3. Has medication overuse headache been ruled out? 4. Will the patient be using the requested agent in combination with another acute migraine therapy (i.e., triptan, 5HT-1F [Reyvow], ergotamine)? 5. Please list the medications the patient has previously tried and failed for treatment of this diagnosis (Please specify if brand name, generic, extended-release products, or over-the-counter products): Date(s):								
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If no, please provide reason:								
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