Prior Authorization Form

Stadol Nasal Spray 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 Stadol Nasal Spray Post Limit.

Drug Name (select from list of drugs shown)

Butorphanol Nasal Spray Stadol (butorphanol) Nasal Spray

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 a diagnosis of migraine headache?	Y N
2. Has medication overuse headache been ruled out?	Y N
3. Is the patient unable to take abortive migraine therapy due to an inadequate treatment response, intolerance, or contraindication?	Y N
[Note: Examples of abortive therapy are triptans, ergotamine, dihydroergotamine, nonsteroidal anti-inflammatory drugs (NSAIDs), mixed analgesics containing caffeine, isometheptene, or butalbital.]	
4. Is the patient currently using migraine prophylactic therapy or unable to take migraine prophylactic therapies due to an	Y N

	inadequate treatment response, intolerance, or contraindication?	
	[Note: Examples of prophylactic therapy are divalproex sodium, topiramate, valproate sodium, metoprolol, propranolol, timolol, atenolol, nadolol, amitriptyline, venlafaxine.]	
5.	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to at least two oral opioids?	Y N
	[If yes, then skip to question 7.]	
6.	Is the patient unable to take oral medications, including liquids?	Y N
7.	Does the patient require MORE than the plan allowance of 4 bottles per month?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date