BlueCross BlueShield Nebraska

Migraine Medications Preauthorization
Policy X.21
Preauthorization Request
Prescriber Fax Form

Only the prescriber may complete this form for prospective reviews.
The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Start saving time by filling out this preauthorization electronically at* MedicalPolicy.NebraskaBlue.com.

What is the priority level of this request?

☐ Standard review - Completed within 15 calendar days of receipt.

☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Patient Information

Today's Date: _____

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):	Telephone Number:

Insurance Information

BCBSNE ID Number:	Group Number:

Physician/Clinic Information

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, ZIP Code:		Phone Number:		Secure Fax Number:

Preauthorization Information

Patient's diagnosis to be treated with requested medication (ICD 10 code): _____

Medication requested: _____ Quantity requested per month: _____

1. Is the patient currently using a migraine prophylactic medication?..... ☐Yes ☐No
2. Is the patient taking this medication in combination with another triptan (e.g., Axert, Amerge, Frova, Imitrex, Maxalt, Relpax, or Zomig) or an ergotamine (e.g., Migranal, DHE or Cafergot)?..... ☐Yes ☐No
3. Please list all other medications the patient is **currently taking** for prophylaxis or treatment of this diagnosis.

   _____

   _____

   _____
4. Please list all medications the patient has **previously tried and failed** for prophylaxis or treatment of this diagnosis.

   _____

   _____

   _____
5. Please include any additional clinical information that should be considered for this review. _____

   _____

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Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726
Phone: 877-999-2374