FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

REQUEST FOR PRIOR AUTHORIZATION
NARCOTIC AGONIST/ANTAGONIST NASAL SPRAYS

This form is used for both preferred and non-preferred agents.

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address: _____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name: _____ Phone: _____

Prescriber Address: _____ Fax: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for narcotic agonist-antagonist nasal sprays. For consideration, the diagnosis must be supplied. If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines. For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration. Payment for non-preferred narcotic agonist-antagonist nasal sprays will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.

Preferred

☐ Butorphanol Tartrate Nasal Spray

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis: _____

If migraine, please **document current prophylactic therapy**:

Drug Name _____ Strength _____ Dosage instructions _____

If not currently using prophylactic therapy, **please document 2 previous trials:**
Trial 1 with prophylactic treatment: Drug Name _____ Strength _____
Dosage instructions _____ Trial Date from _____ Trial Date to _____
Failure documentation _____
Trial 2 with prophylactic treatment: Drug Name _____ Strength _____
Dosage instructions _____ Trial Date from _____ Trial Date to _____
Failure documentation _____

Medical or contraindication reason to override trial requirements: _____
Reason for use of Non-Preferred drug requiring prior approval: _____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.