FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

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.*