Prescriber Criteria Form

Ergotamine 2024 PA Fax 4607-A v1 010124.docx
Cafergot (ergotamine tartrate and caffeine tablet), Migergot (ergotamine tartrate and caffeine suppository)
Coverage Determination

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 **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Ergotamine.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed as therapy to abort or prevent vascular headache (e.g., migraine, migraine variants or so-called “histaminic cephalalgia”)? [If no, then no further questions.]	Yes	No
2	Will the requested drug be used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin)? [If yes, then no further questions.]	Yes	No
3	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to at least ONE triptan 5-HT1 agonist?	Yes	No

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____