Blue Shield Prescription Coverage Request Form -

View our formulary on line at http://www.mylifepath.com If you have a handheld device, you can download the Blue Shield of California formulary and have the latest information at your fingertips by going to www.ePocrates.com.

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information

Our standard turn around time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services at 800.535.9481 to expedite the request.

Physician Information	Patient Information
Name:	Name:
☐ PCP ☐ Specialist: ____________ PLEASE IDENTIFY SPECIALTY	Blue Shield ID#:
Office contact:	Birthdate:
Phone#: ( )	Date of Request:
Facsimile #: ( )	

DRUG REQUESTED:

- ☐ IMITREX (more than 9 tablets per month)
- ☐ IMITREX (more than 2 injection kits w/one refill (#8) per month
- ☐ IMITREX (more than 1 box of nasal spray per month)
- ☐ ZOMIG (more than 6 per month) *non-formulary*
- ☐ AXERT (more than 6 tablets per month) *non-formulary*
- ☐ AMERGE (more than 9 tablets per month)
- ☐ MAXALT (more than 9 tablets per month)
- ☐ MIGRANAL NS (more than #1 kit per month)
- ☐ FROVA (more than 9 tablets per month) *non-formulary*
- ☐ RELPAX (more than 6 tablets per month) *non-formulary*

STRENGTH:	DIRECTIONS:	QUANTITY/MONTH:

PATIENT CLINICAL INFORMATION

1) TYPE OF MIGRAINE:

2) FREQUENCY OF ATTACKS:

3) USAGE PER HEADACHE:

4)DURATION OF HEADACHE:

5) IF USING 2 OR MORE DIFFERENT TRIPTANS, WHEN IS THE PATIENT TO USE WHICH TRIPTAN AND WHY?

6) ABORTIVE MEDICATIONS TRIED AND WHEN?

7) CURRENT MIGRAINE PROPHYLACTIC REGIMEN?

FAX form to: 1.888.697.8122	Pharmacy Services Phone #: 1.800.535.9481

This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above.
If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and **confidentially** destroy the information that faxed in error.
Thank you for your help in maintaining appropriate confidentiality.

Revised: 8/2004

Blue Shield of California

An Independent Member of the Blue Shield Association

PATIENT CLINICAL INFORMATION

8) PREVIOUS PROPHYLACTIC REGIMEN, WHEN, AND OUTCOME?

9) RECENT NEUROLOGY CONSULT (with the past year)? ☐ NO ☐ YES
(if yes, please fax report and last 3 office visit. If none, fax last 3 office visits)

10) LAST OFFICE VISIT DATE:____________________ NEXT OFFICE VISIT DATE:____________________

11) TREATMENT PLAN:

FAX form to: 1.888.697.8122	Pharmacy Services Phone #: 1.800.535.9481

This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above.
If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and **confidentially** destroy the information that faxed in error.
Thank you for your help in maintaining appropriate confidentiality.

Revised: 8/2004