

# Pharmacy Prior Authorization Form

For Prior Authorization please fax to: 616 942-8206

Last Reviewed: May 06

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

## Butorphanol Nasal Spray (butorphanol tartrate)

Member Name: \_\_\_\_\_ Member #: \_\_\_\_\_-\_\_\_\_  
DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Provider Phone: \_\_\_\_\_  
Provider Name: \_\_\_\_\_ Provider Fax: \_\_\_\_\_  
Provider Office Contact Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### Indication:

For the treatment of Post-Operative Analgesia and Migraine Headache pain.

### Precertification Requirements: (Please choose one)

- Post-operative analgesia  
 Migraine headache pain

Documented therapeutic trial and clinical failure with at least two analgesic agents is required:

Medication \_\_\_\_\_ Date of Trial \_\_\_\_\_ Result \_\_\_\_\_  
Medication \_\_\_\_\_ Date of Trial \_\_\_\_\_ Result \_\_\_\_\_

### For Internal Use Only

Approved  Denied  Switch to: \_\_\_\_\_ Date Entered in Argus: \_\_\_\_\_

Effective Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Fills: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_ Product: \_\_\_\_\_