BlueCross BlueShield of North Carolina

BlueMedicare HMO℠
Offered by PARTNERS National Health Plans of North Carolina, Inc.

BlueMedicare PPO℠
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# Butorphanol Tartrate Nasal Spray Quantity Limitation Request Form (Incomplete Forms May Delay Processing)

| PHYSICIAN NAME | | PATIENT NAME |
|---|---|---|
| OFFICE CONTACT PERSON | | PATIENT INSURANCE ID # |
| PHYSICIAN PHONE | PHYSICIAN FAX | PATIENT DATE OF BIRTH |

PHYSICIAN ADDRESS: Street City State Zip

| **QUANTITY LIMITATIONS**: | **Short Term**: **30 days** | **Extended Supply**: **90 days** |
|---|---|---|
| Butorphanol Nasal Spray | 4 canisters | 12 canisters |

Quantity Requested: ______________________________________________

To request quantities greater than above, please check all that are applicable.

1. The patient has post-operative pain and is unable to take oral medications (including liquids). ☐ YES ☐ NO
2. The patient has a diagnosis of moderate to severe migraine headache. ☐ YES ☐ NO
3. The patient has tried and failed at least 2 other abortive migraine therapy agents (e.g., acetaminophen, NSAIDs, combination products such as Fioricet® or Midrin®, 5-HT1 agonists such as Imitrex®, and/or ergot-containing products such as Migranal® or Cafergot®). ☐ YES ☐ NO
   List names of medications: ______________________________________
4. For patients experiencing >4 severe headaches per month, prophylactic therapy has been given an adequate trial. ☐ YES ☐ NO
5. The possibility of medication-incurred, rebound, or chronic daily headache has been considered. ☐ YES ☐ NO

   Some diagnostic criteria for medication-induced headache include: headache that occurs daily or almost daily for more than 6 months, headache pain that is refractory to standard medications, even though the patient is compliant with therapy, and headache present on awakening. In patients with rebound headache, the physician should consider discontinuing the medication.
6. The patient is >65 years old and a diagnosis of an underlying organic disease or other causes of headache have been considered. ☐ YES ☐ NO

I certify that, to the best of my knowledge, the above information is accurate:

Physician signature required: ______________________________________________

**Please Return Completed Form To:** Fax number: 1-888-446-8535
Address: BCBSNC
Attention: Exceptions-Health Services
P.O. Box 17509, Winston-Salem, NC 27116-7509
Provider telephone: 1-888-296-9790

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