

**Butorphanol Tartrate Nasal Spray
Quantity Limitation Request Form**

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:	Extended Supply:
Butorphanol Nasal Spray	30 days 4 canisters	90 days 12 canisters
Quantity Requested: _____		

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

- The patient has post-operative pain and is unable to take oral medications (including liquids). YES NO
- The patient has a diagnosis of moderate to severe migraine headache. YES NO
- 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: _____
- For patients experiencing >4 severe headaches per month, prophylactic therapy has been given an adequate trial. YES NO
- 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.
- 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: 1-888-446-8440
 Address: BCBSNC
 Attention: Exceptions-Health Services
 P.O. Box 17168
 Winston-Salem, NC 27116-7168
 Provider telephone: 1-888-298-7552

10/2009