

**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 |
| <b>QUANTITY LIMITATIONS:</b>  | <b>Short Term:</b><br><b>30 days</b><br>4 canisters | <b>Extended Supply:</b><br><b>90 days</b><br>12 canisters |           |
| Butorphanol Nasal Spray   |   |   |           |
| 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).  |   | <input type="checkbox"/> YES <input type="checkbox"/> NO  |           |
| 2. The patient has a diagnosis of moderate to severe migraine headache.   |   | <input type="checkbox"/> YES <input type="checkbox"/> 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®).<br>List names of medications: _____   |   | <input type="checkbox"/> YES <input type="checkbox"/> NO  |           |
| 4. For patients experiencing >4 severe headaches per month, prophylactic therapy has been given an adequate trial.  |   | <input type="checkbox"/> YES <input type="checkbox"/> NO  |           |
| 5. The possibility of medication-incurred, rebound, or chronic daily headache has been considered.  |   | <input type="checkbox"/> YES <input type="checkbox"/> 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.  |   | <input type="checkbox"/> YES <input type="checkbox"/> 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

10/2009