

Prescriber Criteria Form

Ergotamine 2026 PA Fax 4607-A v2 010126.docx

Ergotamine Products

Migergot (ergotamine tartrate and caffeine suppository), Ergomar (ergotamine tartrate sublingual tablet)

Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Ergotamine Products.

Drug Name (select from list of drugs shown):

**Patient Name:**

**Patient ID:**

**Patient DOB:**

**Patient Phone:**

**Prescriber Name:**

**Prescriber Address:**

**City:**

**State:**

**Zip:**

**Prescriber Phone:**

**Prescriber Fax:**

**Diagnosis:**

**ICD Code(s):**

**Please circle the appropriate answer for each question.**

1	Is the requested drug being prescribed as therapy to abort or prevent vascular headache (e.g., migraine, migraine variants or so-called "histaminic cephalgia")? [If no, then no further questions.]	Yes	No
2	Will the requested drug be used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin)? [If yes, then no further questions.]	Yes	No
3	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to at least ONE triptan 5-HT <sub>1</sub> agonist?	Yes	No

Comments:

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_