

MIGRAINE REFERRAL FORM

Updated Feb 2020

Patient Name _____ Today's Date _____ NEW Patient CURRENT Patient
 DOB _____ Height _____ Weight _____ Male Female Preferred Language _____
 Best Phone _____ Email _____
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Ship to Patient at: Home Physician Office Work Address _____
 Allergies _____
 Current Medications including OTC's (please fax a complete list) _____

Please Fax Insurance Card(s) both sides

Insured's Name _____
 Relation to Patient _____
Primary Insurance _____
 ID# _____ Group # _____
Secondary Insurance _____
 ID# _____ Group # _____

Ordering Prescriber

Office Contact _____
 Street Address _____ Suite # _____
 City _____ State _____ Zip _____
 Tel _____ Fax _____
 Email _____
 License# _____
 NPI# _____

ICD-10 Code _____ **Diagnosis** _____
 Yes No Testing? Yes No Is Patient currently on therapy? Date of next blood work _____
 Yes No Does Patient have a baseline frequency of at least 8 migrains per month? How many? _____
 Yes No Will Patient use in combination with onabotulinumtoxinA (Botox)? **OR**
 Yes No With another CG-RP antagonist, inhibitor?

PRESCRIPTION

AIMOVIG single dose SureClick Autoinjector 70 mg/mL OR 140 mg/mL
 SIG: Inject 70 mg subcutaneously once monthly QTY: 1 Pen Refill: _____
 Inject 140 mg subcutaneously once monthly QTY: 1 Pen Refill: _____

AJOVY 225 mg/1.5 mL PFS
 SIG: Inject 225 mg subcutaneously once monthly QTY: 1 Pen Refill: _____
 Inject 675 mg subcutaneously once every 3 months (3 consecutive injections of 225 mg each) QTY: 3 Pens Refill: _____

EMGALITY 120 mg PFP
 SIG: Inject an initial dose of two 120 mg injections QTY: 2 Pens Refill: _____
 Inject one 120 mg injection for subsequent _____ months QTY: 1 Pen Refill: _____

SUMATRIPTAN INJECTION 6 mg/0.5 mL single dose PFS
 SIG: Inject 6 mg once as needed Kits _____ (1 kit = 2 pre-filled syringes) Refill: _____
 Other: _____ Kits _____ (1 kit = 2 pre-filled syringes) Refill: _____

SUMATRIPTAN NASAL SPRAY single dose nasal spray 5 mg OR 20 mg
 SIG: Administer _____ mg intranasally once as needed
 Other: _____ Kits: _____ (1 kit = 6 nasal spray units) Refill: _____

ONZETRA Xsail 11 mg nasal powder capsule in disposable nosepiece
 SIG: 22 mg, administered by use of one nosepiece (11 mg) in each nostril
 Kits: _____ (1 kit = 8 pouches of 2 ct nosepieces) Refill: _____

ZEMBRACE™ SYMTOUCH™ 3 mg prefilled Autoinjector
 SIG: Inject 3 mg subcutaneously once as needed QTY: _____ Refill: _____

UBRELVY™ tablets 50 mg OR 100 mg
 SIG: Take one tablet as needed for migraine, may repeat at 2 hours (max daily dose is 200 mg) QTY: _____ Refill: _____

ZOMIG NASAL SPRAY single dose nasal spray 2.5 mg OR 5 mg
 SIG: Administer _____ mg intranasally once as needed
 Other: _____ Kits: _____ (1 kit = 6 nasal spray units) Refill: _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.