MIGRAINE REFERRAL FORM

Updated July 2019

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 *(2 consecutive injections of 70 mg each)* — QTY: 2 Pens — Refill: _______

☐ **AJOVY 225 mg/1.5 mL PFS**
SIG: ☐ Inject 225mg subcutaneously once monthly — QTY: 1 Pen — Refill: _______
☐ Inject 675mg 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 120mg injections — QTY: 2 Pens — Refill: _______
☐ Inject one 120mg 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: _______

☐ **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.

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