

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 migraines 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: _____

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: _____

REYVOW 50mg 100mg
SIG: Take 1 tablet by mouth when migraine begins (maximum: 1 dose in 24 hours) QTY: _____ 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: _____

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: _____

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.

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