MIGRAINE ENROLLMENT FORM

PATIENT INFORMATION

Last Name ______________________ First Name ______________________

Social Security No ______________________ Date of Birth ______________________

Sex □ M □ F Weight_____ Height_____ Allergies_________

Home Phone ______________________ Work/Mobile ______________________

Home Address ______________________

City ______________ State ______________ Zip ______________

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ______________________ Medical Insurance Phone ______________________

Subscriber Name ______________________

Rx Card (PBM) ______________________ Group No ______________________

Prescription Card Bin # ______________________ PCN # ______________________

TREATMENT ARRANGEMENTS

•Start Date:_____________ Ship Meds □ Home □ Doctor's Office

STATEMENT OF MEDICAL NECESSITY

DIAGNOSIS:

□ :__________________________ □ Other: ______________________________ Date of Diagnosis: ____________________

Prior Medications: ____ Allergies: ________________________ □ NKDA

PRESCRIPTION INFORMATION

DRUG	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
□ **AIMOVIG** (**erenumab**)	□ 70mg □ 140mg	□ Inject 70mg Subcutaneously once monthly. □ Inject 140mg Subcutaneously dose is administered once monthly as two consecutive injections of 70mg each. □ Others ______________________		
□ **AJOVY** (**fremanezumab**)	□ 225mg □ 675mg	□ Inject 225mg Subcutaneously once a month. □ Inject 675mg Subcutaneously once every quarter. □ Others ______________________		
□ **EMGALITY** (**galcanezumab**)	□ 120mg □	□ **Loading Dose**: Inject 2x120mg Subcutaneously at once. □ **Maintenance Dose**: Inject 120mg Subcutaneously once monthly. □ ______________________		

Physician Signature: X______________________________________ □ **DAW (Dispense as Written) Date:** ____________________

Physician Name: ______________________ **Phone:**____________________ **Fax:**____________________ **Office Contact:**____________________

Physician Address: ______________________________________ **NPI:** ______________________ **DEA:** ____________________

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By Signing this enrollment form you authorize Southside Pharmacy to call Insurance companies on behalf of you for prior authorization purposes.

FAX TO 747-900-8489