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:

□ **G43** Migraine □ **G43.909** Migraine unspecified □ **G44.59** Other complicated headache syndrome

□ **G44.019** Episodic cluster headache, not intractable □ **G80.9** Cerebral palsy unspecified □ **G93.2** Benign intracranial hypertension

□ Other: ______________________________ Date of Diagnosis: ______________________

Prior Medications: ______________________________ Allergies: ______________________ □ **NKDA**

PRESCRIPTION INFORMATION

Migraine Biologics

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) □ Pen □ Syringe	□ 225mg □ 675mg	□ Inject 225mg Subcutaneously once a month. □ Inject 675mg Subcutaneously once every 3 months. □ Others ______	....	....
□ **EMGALITY** (galcanezumab) □ Pen □ Syringe	□ 120mg □ 300mg	□ **Loading Dose**: Inject 2x120mg Subcutaneously at once. □ **Maintenance Dose**: Inject 120mg Subcutaneously once monthly. □ **Episodic Cluster Headache Recommended Dose**: Inject 300mg Subcutaneously administered once monthly as three consecutive injections of 100mg each. □ Others ______	....	....
□ **VYEPTI** (eptinezumab-jjmr)	□ 100mg/ml	□ 100mg in 100mL 0.9%NS IV over 30 minutes Q 3 months. □ Others ______	....	....

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.

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□ Other: ____ Date of Diagnosis: ______________________

Prior Medications: ____ Allergies: __________________________ □ **NKDA**

PRESCRIPTION INFORMATION

Acute Migraine

DRUG	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
□ **NURTEC** **(rimegepant)**	□ 75mg	□ Take 1 tablet by mouth for migraines as needed. Can repeat a dose in 24 hours. □ Others ___________________________	....	....
□ **UBRELVY** **(ubrogepant)**	□ 50mg □ 100mg	□ Take 1 tablet by mouth for migraines as needed. Can repeat one dose in 2 hours. □ Others ___________________________	....	....
□ **ZEMBRACE® SymTouch®** **(sumatriptan succinate)**	3 mg/5mL auto injector	□ Inject 3mg Subcutaneously □ Others ___________________________	....	....

Migraine Prophylaxis

DRUG	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
□ **QUDEXY® XR** **(topiramate)** □ **TROKENDI XR** **(topiramate)**	□ 25mg □ 50mg □ 100mg	□ **Initial Dose:** Take 25mg Capsule by mouth every night for 7 days. □ **Titration Dose:** Increase dose weekly to an effective dose by increments of 25 mg □ Others ___________________________	....	....

	Week1	Week2	Week3	Week4
Dose	*25 mg*	*50 mg*	*75 mg*	*100 mg*
25mg Cap	7 Capsules		7 Capsules	
50mg Cap		7 Capsules	7 Capsules	
100 mg Cap				7 Capsules

Physician Signature: X______________________________ □ **DAW (Dispense as Written) Date:** ______________

Physician Name: ____________________ **Phone:**______________ **Fax:**______________ **Office Contact:**__________

Physician Address: ______________________________ **NPI:** ______________ **DEA:** ______________

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