

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
<input type="checkbox"/> AIMOVIG (erenumab)	<input type="checkbox"/> 70mg <input type="checkbox"/> 140mg	<input type="checkbox"/> Inject 70mg Subcutaneously once monthly. <input type="checkbox"/> Inject 140mg Subcutaneously dose is administered once monthly as two consecutive injections of 70mg each. <input type="checkbox"/> Others _____	.....	.....
<input type="checkbox"/> AJOVY (fremanezumab) <input type="checkbox"/> Pen <input type="checkbox"/> Syringe	<input type="checkbox"/> 225mg <input type="checkbox"/> 675mg	<input type="checkbox"/> Inject 225mg Subcutaneously once a month. <input type="checkbox"/> Inject 675mg Subcutaneously once every 3 months. <input type="checkbox"/> Others _____	.....	.....
<input type="checkbox"/> EMGALITY (galcanezumab) <input type="checkbox"/> Pen <input type="checkbox"/> Syringe	<input type="checkbox"/> 120mg <input type="checkbox"/> 300mg	<input type="checkbox"/> Loading Dose: Inject 2x120mg Subcutaneously at once. <input type="checkbox"/> Maintenance Dose: Inject 120mg Subcutaneously once monthly. <input type="checkbox"/> Episodic Cluster Headache Recommended Dose: Inject 300mg Subcutaneously administered once monthly as three consecutive injections of 100mg each. <input type="checkbox"/> Others _____	.....	.....
<input type="checkbox"/> VYEPTI (eptinezumab-jjmr)	<input type="checkbox"/> 100mg/ml	<input type="checkbox"/> 100mg in 100mL 0.9%NS IV over 30 minutes Q 3 months. <input type="checkbox"/> Others _____	.....	.....

Physician Signature: _____ DAW (Dispense as Written) Date: _____

Physician Name: _____ Phone: _____ Fax: _____ Office Contact: _____

Physician Address: _____ NPI: _____ DEA: _____

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PRESCRIPTION INFORMATION

Acute Migraine

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

Migraine Prophylaxis

DRUG	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> QUDEXY® XR (topiramate) <input type="checkbox"/> TROKENDI XR (topiramate)	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg	<input type="checkbox"/> Initial Dose: Take 25mg Capsule by mouth every night for 7 days. <input type="checkbox"/> Titration Dose: Increase dose weekly to an effective dose by increments of 25 mg <input type="checkbox"/> 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: _____ **DAW (Dispense as Written)** Date: _____

Physician Name: _____ Phone: _____ Fax: _____ Office Contact: _____

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