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

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 ☐ 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.	....	....
☐ **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 _______________________________	....	....
☐ **VYEPTI** (**eptinezumab-jjmr**)	☐ 100mg/ml ☐ 300mg/ml	☐ 100mg in 100mL 0.9%NS IV over 30 minutes Q 3 months. ☐ 300mg 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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