

# 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
<input type="checkbox"/> <b>AIMOVIG</b> (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"/> <b>AJOVY</b> (fremanezumab)	<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 quarter. <input type="checkbox"/> Others _____		
<input type="checkbox"/> <b>EMGALITY</b> (galcanezumab)	<input type="checkbox"/> 120mg <input type="checkbox"/>	<input type="checkbox"/> <b>Loading Dose:</b> Inject 2x120mg Subcutaneously at once. <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 120mg Subcutaneously once monthly. <input type="checkbox"/> _____		

Physician Signature:  \_\_\_\_\_  DAW (Dispense as Written) Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Physician Address: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

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