

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Length of Symptoms: _____ ICD-10: _____
 Other diagnosis _____ Number of Migraine Days per month: _____
 Headache Days per month: _____ Migraine Hours per day: _____
 Patient has been evaluated and does not have medication overuse headache? No Yes
 MIDAS Score: _____
 Aura Symptoms Present? No Yes If yes, list symptoms: _____
 Hepatic impairment: None Mild Moderate Severe
 Renal Impairment : Yes No CrCl: _____
 Patient also taking Botox®? No Yes

For Acute Treatment:

Does patient have a contraindication to triptan therapy? No Yes
 If yes: CAD History of stroke PVD Uncontrolled hypertension Other: _____
For Reyvow®: patient agrees to not engage in activities requiring mental alertness for 8 hours after each dose No Yes
 Was requested medication provided as a sample in MD office? Yes No

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Prior Failed Treatments:

- Preventative:**
 ACE-I/ARBs
 Antiepileptics
 Beta Blockers
 CCBs
 OnabotulinumtoxinA
 TCAs
 Other Antidepressants
 Supplements
 Other
Abortive:
 Ergots
 NSAIDs
 Injectable Triptans
 Nasal Triptans
 Oral Triptans
 Other

Indicate Drug Name and Length of Treatment:

4 INJECTION TRAINING: To Be Administered by Pharmacist (State of Missouri Only) Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> AIMOVIG®	<input type="checkbox"/> 70mg/ml SureClick® Autoinjector <input type="checkbox"/> 70mg/ml Prefilled Syringe <input type="checkbox"/> 140mg/ml SureClick® Autoinjector <input type="checkbox"/> 140mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 70mg SC once a month <input type="checkbox"/> Inject 140mg SC once a month	1	
<input type="checkbox"/> AJOVY®	<input type="checkbox"/> 225mg/1.5ml Prefilled Syringe <input type="checkbox"/> 225mg/1.5ml Prefilled Autoinjector	<input type="checkbox"/> Inject 225mg SC once a month <input type="checkbox"/> Inject 675mg SC every 3 months <i>(Inject three 225mg/1.5ml injections consecutively)</i>	1 3	
<input type="checkbox"/> BOTOX®	<input type="checkbox"/> 100 Units Single-Dose Vial <input type="checkbox"/> 200 Units Single-Dose Vial	<input type="checkbox"/> Inject 0.1ml (5 Units) intramuscularly per each site divided across 7 head/neck muscles Recommended total dose is 155 units		
<input type="checkbox"/> EMGALITY®	<input type="checkbox"/> 100mg/ml Prefilled Syringe For Cluster Headaches <input type="checkbox"/> 120mg/ml Prefilled Pen <input type="checkbox"/> 120mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 300mg SC administered as 3 consecutive injections of 100mg each at the onset of the cluster period, then monthly until the end of the cluster period <input type="checkbox"/> Loading Dose: Inject 240mg SC administered as 2 consecutive injections of 120mg each on Day 1 <input type="checkbox"/> Maintenance Dose: Inject 120mg SC once a month starting on Day 29	3 2	
<input type="checkbox"/> NURTEC™ ODT	<input type="checkbox"/> 75mg Orally Disintegrating Tablet Maximum dose in a 24-hour period is 75mg.	Acute treatment of migraine <input type="checkbox"/> Take one orally disintegrating tablet by mouth as needed. Preventive treatment of episodic migraine: <input type="checkbox"/> Take 75 mg tablet orally every other day	8	
<input type="checkbox"/> REYVOW®	<input type="checkbox"/> 50mg Tablet <input type="checkbox"/> 100mg Tablet	<input type="checkbox"/> Take _____ tablet(s) orally with or without food. Only one dose should be taken in 24 hours. <i>*Avoid driving or operating machinery for at least 8 hours after taking medication.</i>	8	
<input type="checkbox"/> UBRELVY®	<input type="checkbox"/> 50mg Tablet <input type="checkbox"/> 100mg Tablet	<input type="checkbox"/> Take orally with or without food. If needed a second dose may be taken at least 2 hours after the initial dose. <i>*Dose adjustments or avoidance is necessary with concomitant use of certain drugs and patients with severe hepatic or renal impairment.</i>	6 8 10 12 30	
<input type="checkbox"/>				

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payer based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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