

**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)**

Date of Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_  
Select Diagnosis:  Chronic migraines  Episodic cluster headache  Episodic migraines  
 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  
Type of Migraine:  Fully Reversible  Partially Reversible  
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

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

**Prior Failed Treatments:**

**Indicate Drug Name and Length of Treatment:**

**Preventative:**

- ACE-I/ARBs (lisinopril, candesartan) \_\_\_\_\_
- Antiepileptics (divalproex, gabapentin, topiramate) \_\_\_\_\_
- Beta Blockers (propranolol, timolol) \_\_\_\_\_
- CCBs (nimodipine, verapamil) \_\_\_\_\_
- OnabotulinumtoxinA (Botox®) \_\_\_\_\_
- TCAs (amitriptyline, doxepin) \_\_\_\_\_
- Other Antidepressants (venlafaxine) \_\_\_\_\_
- Supplements (magnesium, riboflavin) \_\_\_\_\_
- Other \_\_\_\_\_

**Abortive:**

- Ergots (Migranal®) \_\_\_\_\_
- NSAIDs (ibuprofen, indomethacin) \_\_\_\_\_
- Injectable Triptans (Zembrace®) \_\_\_\_\_
- Nasal Triptans (Onzetra Xsail®, Zomig®) \_\_\_\_\_
- Oral Triptans (Axert®, Amerge®, Frova®, Imitrex®, Maxalt®, Relpax®) \_\_\_\_\_
- Other \_\_\_\_\_

**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 <i>For Cluster Headaches</i> <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"/> <b>Loading Dose:</b> Inject 240mg SC administered as 2 consecutive injections of 120mg each on Day 1 <input type="checkbox"/> <b>Maintenance Dose:</b> Inject 120mg SC once a month starting on Day 29	3 2	
<input type="checkbox"/> NURTEC™ ODT	<input type="checkbox"/> 75mg Orally Disintegrating Tablet	<input type="checkbox"/> Take one orally disintegrating tablet by mouth as needed. Maximum dose in a 24-hour period is 75mg.	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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