Gateway Pharmacy Specialty Care

MIGRAINE SPECIALTY CARE PROGRAM

Phone: **888-570-4487** • Fax: **844-899-4226**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

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: _____

Number of Migraine Attacks:

❑ Per Day: _____ ❑ Per Month: _____

Type of Migraine: ❑ Fully Reversible ❑ Partially Reversible

Aura Symptoms Present? ❑ No ❑ Yes ❑ If yes, list symptoms: _____

Please attach any of the following (if applicable):

❑ Angiography ❑ Blood & Urine Chemistry ❑ Eye Examination(s) ❑ X-Ray ❑ Other

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
❑ Botox	
❑ Ergots	
❑ NSAIDS	
❑ Triptans	
❑ Other	

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

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ 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
❑ AIMOVIG™	❑ 70mg/ml SureClick® Autoinjector	❑ Inject 70mg SC once a month	1	
	❑ 70mg/ml Prefilled Syringe	❑ Inject 140mg SC once a month *(Inject two 70mg/ml injections consecutively)*	2	
❑ BOTOX®	❑ 100 Units Single-Dose Vial ❑ 200 Units Single-Dose Vial	❑ Inject 0.1mL (5 Units) intramuscularly per each site divided across 7 head/neck muscles. Recommended total dose is 155 units.		
❑ _____	_____	_____		
❑ _____	_____	_____		

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 payor 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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