

**MIGRAINE SPECIALTY CARE PROGRAM**

Phone: **844-MILLRX-0** • Fax: **844-468-7606**

**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: \_\_\_\_\_  
 Patient also taking Botox?  No  Yes  
 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:
<input type="checkbox"/> Botox	_____
<input type="checkbox"/> Ergots	_____
<input type="checkbox"/> NSAIDS	_____
<input type="checkbox"/> Triptans	_____
<input type="checkbox"/> 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:**  To Be Administered by Pharmacist  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"/> Inject 70mg SC once a month	1	
	<input type="checkbox"/> 70mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 140mg SC once a month <i>(Inject two 70mg/ml injections consecutively)</i>	2	
<input type="checkbox"/> AJOVY™	<input type="checkbox"/> 225mg/1.5ml Prefilled Syringe	<input type="checkbox"/> Inject 225mg SC once a month	1	
		<input type="checkbox"/> Inject 675mg SC every 3 months <i>(Inject three 225mg/1.5ml injections consecutively)</i>	3	
<input type="checkbox"/> BOTOX®	<input type="checkbox"/> 100 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"/> 200 Units Single-Dose Vial			
<input type="checkbox"/> EMGALITY™	<input type="checkbox"/> 120mg/ml Prefilled Pen <input type="checkbox"/> 120mg/ml Prefilled Syringe	<input type="checkbox"/> <b>Loading Dose:</b> Inject 240mg SC administered as 2 consecutive injections of 120mg each on Day 1	2	
		<input type="checkbox"/> <b>Maintenance Dose:</b> Inject 120mg SC once a month starting on Day 29	1	
<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 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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