PROFESSIONAL PHARMACY GROUP
Specialty Care

MIGRAINE SPECIALTY CARE PROGRAM

Phone: **844-223-7510** • Fax: **844-673-6161**

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: ____________

v9.2_061218

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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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