PROFESSIONAL PHARMACY GROUP
Specialty Pharmacy

MIGRAINE SPECIALTY CARE PROGRAM

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

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: _____
Office Contact: _____ Phone: _____
Email: _____

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:
❑ 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 REQUIRED INFORMATION: Front & back copies of pharmacy & medical cards along with charts & labs from last 90 days

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 ❑ 70mg/ml Prefilled Syringe	❑ Inject 70mg SC once a month ❑ Inject 140mg SC once a month *(Inject two 70mg/ml injections consecutively)*	1 2	
❑ AJOVY™	❑ 225mg/1.5ml Prefilled Syringe	❑ Inject 225mg SC once a month ❑ Inject 675mg SC every 3 months *(Inject three 225mg/1.5ml injections consecutively)*	1 3	
❑ 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		
❑ EMGALITY™	❑ 120mg/ml Prefilled Pen ❑ 120mg/ml Prefilled Syringe	❑ **Loading Dose:** Inject 240mg SC administered as 2 consecutive injections of 120mg each on Day 1 ❑ **Maintenance Dose:** Inject 120mg SC once a month starting on Day 29	2 1	
❑ _____	_____	_____		

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.