

**PATIENT INFORMATION**

Name:	Date of Birth:	<input type="radio"/> Male <input type="radio"/> Female	
Address:	City:	State:	Zip:
Phone:	Alt Phone:	Email:	
SS #:	Primary Language:	Emergency Contact:	

**PRESCRIBER INFORMATION**

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:	Office Contact:		

**MEDICAL INFORMATION**

**\*\* PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY \*\***

O ICD-10 Code & Description: _____	
Patient Evaluation:	Previous medications tried: _____
Height: _____ in/cm	Weight: _____ kg/lbs
Allergies: _____	Name: _____ Date: _____
	Name: _____ Date: _____

**PRESCRIPTION INFORMATION**

Needs by Date:	Ship to: <input type="radio"/> Patients home <input type="radio"/> Prescriber 1st order only <input type="radio"/> Prescriber all orders <input type="radio"/> Other			
Drug	Dose	Directions	Quantity	Refills
O Aimovig (erenumab-aooe) injection	O 70 mg Autoinjector	O Inject 70mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen	O 1 Pen	
	O 140 mg Autoinjector	O Inject 140mg subcutaneously once every 4 weeks into the upper arm, thigh, or abdomen. (2 x 70mg consecutively.)	O 2 Pen	
O Ajovy (fremanezumab-yfrm)	O 225 mg/1.5 mL PFS	O Inject 225mg subcutaneously once a month into the upper arm, thigh, or abdomen or O Inject 675mg subcutaneously once every 3 months into the upper arm, thigh, or abdomen. The 675mg quarterly dosage is administered as three consecutive injections of 225 mg each.	O 1 Pen O 3 Pens	
O Emgality (galcanezumab-gnlm)	O 120 mg PFP	O Inject an initial dose of two 120mg injections O Inject one 120mg injection for subsequent _____ months.	O 2 Pens O 1 Pen	
O Botox (onabotulinumtoxin A)	O 200 Units	Recommended total dose 155 Units, as 0.1mL (5 Units). Injections per each site divided across 7 head/neck muscles.	O 1 Vial	
O Vyepti (eptonezumab-jjmr)	O 100mg/mL solution	O Infuse 100mg over approximately 30 minutes every 3 months. Dilute only in 100mL of 0.9% Sodium Chloride Injection		

**PRESCRIBING PRACTITIONER SIGNATURE**

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: \_\_\_\_\_

Date \_\_\_\_\_

**CONFIDENTIALITY NOTICE**

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Faxed Prescriptions will only be accepted from a prescribing practitioner.