

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:
<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: 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
<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"/> 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"/> _____	_____	_____		
<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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