Migraine Referral Form

Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: ☐Male ☐Female Weight_____ ☐lbs. ☐kg
Preferred Phone: _____ Known Allergies_____
Address: _____ City: _____ State_____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Prescriber Name: _____ NPI#_____ Tax ID#_____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____

3. Diagnosis/Clinical Information

Diagnosis:_____ ICD-10: _____

Has the patient ever received botulinum toxin injection migraine? ☐ Yes ☐ No
Has the patient been evaluated for medication overuse headache? ☐ Yes ☐ No
Does the patient have a diagnosis of episodic migraine: ☐ Yes ☐ No

**If yes, please select all that apply:

- ☐ Patient has more than 4 migraine headaches per month
- ☐ Migraine headaches last longer than 12 hours
- ☐ Migraine attacks that cause significant disability or diminished quality of life despite appropriate acute treatment
- ☐ Contraindications to acute therapies
- ☐ Tried and received inadequate response to acute therapies
- ☐ At risk for medication overuse headache without preventive therapy

Serious side effects to acute therapies

Prior migraine prophylaxis therapy:
*Please include approx. dates and duration if known:

_____
_____
_____
_____

Other medications Patient has tried and Failed:

_____
_____
_____
_____

Please FAX recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

4. Prescription Information

Medication	Dose/Strength	Sig	QTY.	Refills
☐ Aimovig®	☐ 70 mg/mL SureClick® Autoinjector ☐ 70 mg/mL Prefilled syringe	☐ Inject 1 SureClick® Pen SC (70mg) every month ☐ Inject 2 SureClick® Pens SC (140mg) every month ☐ Inject 1 Prefilled syringe SC (70mg) every month ☐ Inject 2 Prefilled syringes SC (140mg) every month	QS	
☐ Ajovy®	☐ 225 mg/1.5 mL prefilled syringe	☐ Inject 1 Prefilled syringe SC (225mg) every month ☐ Inject 3 Prefilled syringes SC (675Mg) every 3 months	1Box 3 Boxes	
☐ Emgality®	☐ 120 mg/ml single-dose prefilled pen ☐ 120 mg/ml single-dose prefilled syringe	☐ Loading Dose: Inject 240mg SC the first month ☐ Maintenance: Inject 120mg SC every month	QS	
☐ Other				

Dispensing Options: ☐Patient ☐ Prescriber's Office

Prescriber Signature: Prescriber, please sign and date below

Dispense as Written Date	Substitution Permitted Date

I authorize Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.