PHARMACA
SPECIALTY PHARMACY

MIGRAINE ENROLLMENT FORM

Fax: **888-882-3341**
Call 24/7: **855-465-8892**

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt Phone: _____
Email: _____
DOB: _____ ☐ M ☐ F Last 4 of SSN: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Office Contact: _____ Phone: _____

3 INSURANCE INFORMATION:

Please attach front and back copies of prescription/medical insurance card(s).

4 CLINICAL INFORMATION:

To expedite prior authorization, please attach relevant clinical documentation.

Primary ICD-10: _____ Drug Allergies: ☐ NKDA ☐ _____

If prior authorization is denied, preferred alternatives or the option to appeal, if available, will be provided to the office.

Additional Information: _____

5 INJECTION TRAINING:

☐ Physician to Train ☐ Pharmacist to Train ☐ Other: _____

6 PRODUCT DELIVERY:

☐ Physician's Office ☐ Patient's Home ☐ Other: _____

PRESCRIPTION INFORMATION:

Medication	Dose/Strength	Directions	Qty	Refills
☐ **Aimovig™**	☐ 70mg/ml SureClick® Autoinjector ☐ 70mg/ml Prefilled Syringe	☐ Inject 70mg SC once a month	1	
		☐ Inject 140mg SC once a month (Inject two 70mg/ml injections consecutively)	2	
☐ **Ajovy™**	☐ 225mg/1.5ml Prefilled Syringe	☐ Inject 225mg SC once a month	1	
		☐ Inject 675mg SC every 3 months (Inject three 225mg injections consecutively)	3	
☐ **Botox®**	☐ 100 Units Single-Dose Vial ☐ 200 Units Single-Dose Vial	☐ Inject 5 units (0.1ml) IM per each site divided across 7 head/neck muscles. Recommended total dose is 155 units.		
☐ **Emgality™**	☐ 120mg/ml Prefilled Pen ☐ 120mg/ml Prefilled Syringe	☐ **Induction:** Inject 240mg SC one time (Inject two 120mg/ml injections consecutively)	2	
		☐ **Maintenance:** Inject 120mg SC once a month	1	
☐	☐	☐		

I authorize Pharmaca and its affiliates to act on my behalf to obtain prior authorization and/or other assistance if applicable. I acknowledge that prior authorization/payment is not guaranteed.

X PHYSICIAN SIGNATURE REQUIRED

Substitution Permitted Date

X _____

Dispense as Written Date