PHARMACA
SPECIALTY PHARMACY

MIGRAINE ENROLLMENT FORM

Fax: **888.882.3341**
Call: **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 and Form	Directions	Qty	Refills
☐ **Aimovig**	☐ 70 mg/mL SureClick Autoinjector ☐ 70 mg/mL Prefilled Syringe	☐ Inject 70 mg SC once a month ☐ Inject 140 mg SC once a month (Inject two 70 mg/mL injections consecutively)	1 2	
☐ **Ajovy**	☐ 225 mg/1.5 mL Prefilled Syringe ☐ 225 mg/1.5 mL Prefilled Autoinjector	☐ Inject 225 mg SC once a month ☐ Inject 675 mg SC every 3 months (Inject three 225 mg injections consecutively)	1 3	
☐ **Botox**	☐ 100 Units Single-Dose Vial ☐ 200 Units Single-Dose Vial	☐ Inject 5 units (0.1 mL) IM per each site divided across 7 head/neck muscles. Recommended total dose is 155 units.		
☐ **Emgality**	☐ 120 mg/mL Prefilled Pen ☐ 120 mg/mL Prefilled Syringe	☐ **Induction:** Inject 240 mg SC one time (Inject two 120 mg/mL injections consecutively) ☐ **Maintenance:** Inject 120 mg SC once a month	2 1	0
☐ **Ubrelvy**	☐ 50 mg Tablets ☐ 100 mg Tablets	☐ Take one tablet as needed for migraine. May repeat at 2 hours. Do not exceed 200 mg per day.	10	
☐				

I authorize Pharmacaand 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 | Dispense as Written | Date