



Migraine Enrollment Form

All our referral forms are available on our website.

www.pyramidspharmacy.com

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____

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

Plan Name: _____ Plan Phone: _____
 ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (_____) _____ - _____

3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis (ICD-10):
 G43.7 Chronic Migraine without Aura
 Other: _____

Prior Failed Medications:
 NSAIDs: _____ Triptans: _____
 Beta-Blocker(s): _____ Antidepressant(s): _____
 Anticonvulsant(s): _____ Onabotulinumtoxin A: _____
 Other: _____

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
Injectables:				
<input type="checkbox"/> Aimovig™	<input type="checkbox"/> 70 mg/mL SureClick® Autoinjector (pk of 1) <input type="checkbox"/> 70 mg/mL SureClick® Autoinjector (pk of 2)	<input type="checkbox"/> Inject _____ mg subQ once monthly.		
<input type="checkbox"/> Ajovy™	<input type="checkbox"/> 225 mg/1.5 mL PFS	<input type="checkbox"/> Inject 225 mg subQ monthly. <input type="checkbox"/> Inject 675 mg subQ every 3 months.		
<input type="checkbox"/> Botox®	<input type="checkbox"/> 100 Unit Vial <input type="checkbox"/> 200 Unit Vial	<input type="checkbox"/> Inject _____ units IM divided among affected area(s) by physician only. (Dose not recommended to be repeated within 12 weeks.) <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Emgality™	<input type="checkbox"/> 120 mg/mL Single-Dose Prefilled Pen <input type="checkbox"/> 120 mg/mL Single-Dose Prefilled Pen (carton of 2)	<input type="checkbox"/> Initial Dose: Inject 240 mg (two 120 mg injections) subQ as a single dose, followed by maintenance dose. <input type="checkbox"/> Maintenance Dose: Inject 120 mg subQ once monthly.		
Compounds:				
<input type="checkbox"/> Sumatriptan 1%, Promethazine 2%, Ketoprofen 3%, Lidocaine 3% Cream		<input type="checkbox"/> Apply to temple on affected side(s) as needed for migraine up to 4 times a day.	120 grams	
<input type="checkbox"/> Ketamine 2.5%, Lidocaine 4% Spray		<input type="checkbox"/> Use 1 to 2 sprays in nostril on the affected side(s) as needed for migraine; may repeat after one hour. Not to exceed 4 sprays per day.	10 mls	
<input type="checkbox"/> Ondansetron 0.8% in Lipoderm		<input type="checkbox"/> Apply 2 to 4 clicks to wrist three times daily as needed for nausea.	30 grams	

Deliver to: Patient Office Other: _____ Date: _____ Needs by Date: _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution Permitted Dispense as Written

STAMP SIGNATURE NOT ALLOWED Prescriber's Signature: _____ Date: _____

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.