Migraine Enrollment Form

All our referral forms are available on our website.

www.pyramidspharmacy.com

10970 Shadow Creek Pkwy, Suite 110.1 I Pearland, TX 77584 I Phone: 1.888.375.1920 I 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:				
❑ Aimovig™	❑ 70 mg/mL SureClick® Autoinjector (pk of 1) ❑ 70 mg/mL SureClick® Autoinjector (pk of 2)	❑ Inject ______ mg subQ once monthly.		
❑ Ajovy™	❑ 225 mg/1.5 mL PFS ❑ 225 mg/1.5 mL Auto-Injector	❑ Inject 225 mg subQ monthly. ❑ Inject 675 mg subQ every 3 months.		
❑ Botox®	❑ 100 Unit Vial ❑ 200 Unit Vial	❑ Inject ______ units IM divided among affected area(s) by physician only. (Dose not recommended to be repeated within 12 weeks.) ❑ Other: ______		
❑ Emgality™	❑ 120 mg/mL Single-Dose Prefilled Pen ❑ 120 mg/mL Single-Dose Prefilled Pen (carton of 2)	❑ **Initial Dose**: Inject 240 mg (two 120 mg injections) subQ as a single dose, followed by maintenance dose. ❑ **Maintenance Dose**: Inject 120 mg subQ once monthly.		

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.