**866 413-3156** toll free phone
**877 834-1231** toll free fax
QUESTIONS? Please contact us!
www.REPharmacy.com

# Migraine Prescription Referral Form

***Send your Rx to:*** ______________________

Date Medication Needed: ____________ Ship To: ( ) Patient's Home ( ) Prescriber's Office ( ) Pick-up (store location): ____________________ Injection training by pharmacy? ☐

## 1. Patient Information | Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: ______________________ Birth Date: __________
Soc. Sec. #: ______________ Preferred Phone: ______________
Address: ____________________________________________
Alternate Caregiver Name: ______________________________

Sex: ( ) Male ( ) Female Height: ______ Weight: ______ ( ) lbs. ( ) kg.
Known Allergies: ______________________________________
City: __________________________ State: ______ Zip: ________
Preferred Phone: ______________________________________

## 2. Prescriber Information

Provider Name: ____________________ Specialty: __________
Address: ____________________________________________
City, State, Zip: _______________________________________

DEA#: ___________ NPI#: ___________ Tax ID#: ___________
Phone: ______________________ Fax: ____________________
Key Contact: __________________ Phone: _________________

## 3. Diagnosis/Clinical Information

Please FAX recent clinical notes, labs, tests, with the prescription to expedite the prior authorization.

**Diagnosis:** Migraine Prophylaxis ( ) Yes ( ) No **Pregnancy:** ( ) Yes ( ) No **Breast Feeding:** ( ) Yes ( ) No

**Failed prior therapy:** ( ) Yes ( ) No **Indicate:** ______________________________________

**Allergy:** ☐ Ajovy ☐ Emgality ☐ Aimovig ☐ Other: ______________________________ **Latex:** ( ) Yes ( ) No

**Provided by:** ☐ Doctor's Office ☐ Caregiver ☐ Patient **Training Required:** ( ) Yes ( ) No **Notes:** ______________

## 4. Prescription Information

| Drug Name | Strenght | Dose / Frequency / Route | Refill |
|---|---|---|---|
| ☐ **Ajovy** (Fremanezumab-vfrrm) | ☐ 225mg/1.5ml prefilled syringe | ☐ 225 mg SC every month<br>☐ 675 mg SC (225 mg x3) every 3 months | |
| ☐ **Emgality** (Galcanezumab-gnlm) | ☐ 120mg/ml prefilled syringe | ☐ Loading Dose: 240 mg SC (120mg/ml x2)<br>☐ Maintenance Dose: 120 mg SC once monthly | |
| ☐ **Aimovig** (Erenumab-aooe) | ☐ 70 mg/ml prefilled syringe | ☐ 70 mg SC once monthly<br>☐ 140 mg SC once monthly (70 mg SC x 2) | |
| ☐ **Other** | | | |

## 5. Patient Support Programs

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

**Patient Signature** ______________________ **Date** ____________

## 6. Prescriber Signature

Prescriber, please sign and date below

*By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.*

**Dispense as written** ______________ **Date** ________ **Substitution Permissible** ______________ **Date** ________

**IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. **Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.**

**# of Prescriptions:** ________

*Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.*

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