DR IKE'S SPECIALTY PHARMACY

Neurology ORDER FORM

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1 Patient Information *(Please complete the following information)*

Patient Name (First, MI, Last): _____ DOB: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____ ☐ PLEASE ATTACH DEMOGRAPHIC INFORMATION

2 Insurance Information ☐ PLEASE ATTACH FRONT & BACK OF PATIENT'S INSURANCE CARD, PRESCRIPTION CARD, AND/OR MEDICAID CARD.

Primary Insurance Name: _____ Primary Insurance ID: _____

Insurance Phone Number: _____ Policyholder Name: _____

Secondary Insurance Name: _____ Primary Insurance ID: _____

Insurance Phone Number: _____ Policyholder Name: _____

3 Clinical Information ☐ PLEASE FAX CLINICAL DOCUMENTATION TO PHARMACY ALONG WITH REFERRAL FORM.

Diagnosis (ICD-10 Code): _____ Date Migraines started: _____ Number of headache days per month: _____

Allergies: _____

Previous Acute Migraine Medication (last 3 months):

Name of drug and dose	Duration	Outcome (effective, suboptimal, intolerant, failed)	Discontinued (Y/N) Reason?

Previous Prophylactic Migraine Medication (last 3 months):

Name of drug	Class	Outcome (effective, suboptimal, intolerant, failed)	Discontinued (Y/N) Reason?

4 Prescriber Information

Practice Name: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Phone: _____ Fax: _____

5 Prescribing Information & Authorization

☐ May Substitute ☐ May NOT Substitute

Drug: Emgality–120mg or 300mg Injection SIG: _____ Qty: _____ Refills: _____

Aimovig–70mg/ml or 140mg/ml Injection SIG: _____ Qty: _____ Refills: _____

Ajovy–225mg/1.5ml Injection SIG: _____ Qty: _____ Refills: _____

Migranal–Nasal Spray SIG: _____ Qty: _____ Refills: _____

Nurtec–75mg Tablets SIG: _____ Qty: _____ Refills: _____

Ubrelvy–50mg or 100mg Tablets SIG: _____ Qty: _____ Refills: _____

Zomig–2.5mg or 5mg Nasal Spray SIG: _____ Qty: _____ Refills: _____

Custom Medications _____ Total # of medications prescribed: 1 2 3 4 5 6 7

Prescriber's Signature: _____ Date: _____