

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: _____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by the express authority of the sender to the named addressee.