MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

MIGRAINE

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:			Secondary Insurance:	
ID#:	RxBin:		ID#:	RxBin:
RxGroup:	Pcn:		RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ AIMOVIG	☐ 70MG/ML AUTOINJECTOR ☐ 140MG/ML AUTOINJECTOR	☐ INJECT_____MG SQ EVERY 4 WEEKS		
☐ AJOVY	☐ 225MG/1.5ML PFS ☐ 225MG/1.5ML AUTOINJECTOR	☐ INJECT 225MG SQ EVERY 4 WEEKS ☐ INJECT 675MG SQ EVERY 3 MONTHS		
☐ ELYXYB	☐ 120MG/4.8ML ORAL SOLUTION	☐ TAKE 120 MG ORALLY, WITH OR WITHOUT FOOD AS DIRECTED BY PRESCRIBER. MAX DOSAGE IN A 24-HOUR PERIOD IS 120 MG.	[28.8 ML]	
☐ EMGALITY	☐ 100MG PFS ☐ 120MG PFS ☐ 120MG AUTOINJECTOR	☐ INJECT_____MG SQ EVERY 4 WEEKS		
☐ MIGERGOT	☐ 2mg/100mg SUPPOSITORY	☐ ADMINISTER ONE SUPPOSITORY AT START OF ATTACK; SECOND SUPPOSITORY AFTER 1 HOUR, IF NEEDED FOR FULL RELIEF.	[12]	
☐ NURTEC	☐ (75MG) TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE EVERY OTHER DAY ☐ TAKE 1 TABLET BY MOUTH AS NEEDED. NO MORE THAN 1 TABLET PER DAY	[8] OR [16]	
☐ ONZETRA	☐ 11MG KIT	☐ TAKE 22 MG, ADMINISTERED BY USE OF ONE NOSEPIECE (11 MG) IN EACH NOSTRIL. MAX DOSE IN A 24-HOUR PERIOD SHOULD NOT EXCEED TWO DOSES (44 MG) SEPARATED BY AT LEAST 2 HOURS.	1 DEVICE	

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone numbers set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Please fax completed form to 1 (855) 595-2955

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Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ QULIPTA	☐ 10MG TABLET ☐ 30MG TABLET ☐ 60MG TABLET	☐ TAKE 1 TABLET BY MOUTH ONCE DAILY	[30]	
☐ REYVOW	☐ 50MG TABLET ☐ 100MG TABLET	☐ TAKE 1 TABLET BY MOUTH AS NEEDED. NO MORE THAN 1 TABLET PER DAY	[8]	
☐ SYMBRAVO	☐ 20MG/10MG TABLET	☐ TAKE 1 TABLET BY MOUTH AS NEEDED. NO MORE THAN 1 TABLET PER DAY	[9]	
☐ TOSYMRA	☐ 10MG NASAL SPRAY	☐ ADMINISTER A SINGLE DOSE OF 10 MG OF NASAL SPRAY. MAXIMUM DOSE IN A 24-HOUR PERIOD: 30 MG; SEPARATE DOSES BY AT LEAST ONE HOUR.	1 DEVICE	
☐ TRUDHESA	☐ 0.725 MG NASAL SPRAY	☐ ADMINISTER ONE METERED SPRAY OF 0.725 MG INTO EACH NOSTRIL AS NEEDED. REPEAT, IF NEEDED, A MINIMUM OF 1 HOUR AFTER THE FIRST DOSE. NO MORE THAN 2 DOSES WITHIN A 24-HOUR PERIOD OR 3 DOSES WITHIN 7 DAYS.		
☐ UBRELVY	☐ 50MG TABLET ☐ 100MG TABLET	☐ TAKE 1 TABLET BY MOUTH AS NEEDED. NO MORE THAN 2 TABLETS PER DAY	[10] OR [16]	
☐ ZAVZPRET	☐ 10MG NASAL SPRAY	☐ ADMINISTER 10 MG GIVEN AS A SINGLE SPRAY IN ONE NOSTRIL, AS NEEDED. MAXIMUM DOSE IN A 24-HOUR PERIOD IS 10 MG (ONE SPRAY).	[6]	
☐ ZEMBRACE	☐ 3MG/0.5ML AUTOINJECTOR	☐ INJECT 3 MG SQ AS NEEDED. MAX DOSE IN A 24-HOUR PERIOD IS 12 MG. SEPARATE DOSES BY AT LEAST 1 HOUR.	1 KIT	

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Address: City: State: Zip Code:

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