

# MIGRAINE

## Prescription Referral Form

Phone: 843-352-7662 | Fax: 833-898-3992 | Backup Fax 843-352-7629 | 1501 Belle Isle Ave #150 Mt Pleasant SC 29464

### PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ Patient Preferred Language:  English  Spanish  \_\_\_\_\_

### PRESCRIBER INFORMATION

Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Office's Preferred Method of Contact:  Phone  Fax  Portal  Email: \_\_\_\_\_  Other: \_\_\_\_\_

### PATIENT CLINICAL INFORMATION / HISTORY -PLEASE FORWARD ALL CHART NOTES AND LABWORK

Diagnosis: \_\_\_\_\_ ICD 10:  G43.709  Other: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
 Number of Headache Days per month: \_\_\_\_\_ Number of Headache Hours per day: \_\_\_\_\_ Drug Allergies: \_\_\_\_\_  
 Previous / Failed Medications: \_\_\_\_\_

### PRESCRIBING INFORMATION

NEW  RESTART  CONTINUING | SHIPPING PREFERENCE:  Deliver Medication to Patient  Deliver Medication to MDO

MEDICATION	DOSAGE	SIG	QTY	RFLS
<input type="checkbox"/> AIMOVIG	<input type="checkbox"/> 70mg/mL Pen <input type="checkbox"/> 140mg/mL PFS	<input type="checkbox"/> Inject 70mg SC once monthly <input type="checkbox"/> Inject 140mg SC once monthly		
<input type="checkbox"/> AJOVY	<input type="checkbox"/> 225mg/1.5mL PFS <input type="checkbox"/> 225mg/1.5mL Autoinjector	<input type="checkbox"/> Inject 225mg SC once monthly <input type="checkbox"/> Inject 675mg SC every 3 months		
<input type="checkbox"/> BOTOX	<input type="checkbox"/> 100mg Unit Vial	<input type="checkbox"/> _____ _____		
<input type="checkbox"/> EMGALITY	<input type="checkbox"/> 120mg/mL PFS <input type="checkbox"/> 120mg/mL Pen <input type="checkbox"/> 100mg/mL PFS	<input type="checkbox"/> <u>Induction Dose</u> : Inject 240mg SC on day 1		
		<input type="checkbox"/> <u>Maintenance Dose</u> : Inject 120mg SC once monthly		
<input type="checkbox"/> NURTEC OTD	<input type="checkbox"/> 75mg Tablet	<input type="checkbox"/> Take 75mg by mouth as needed (MAX of 1 tablet every 24 hours)		
		<input type="checkbox"/> Take 75mg by mouth once every other day		
<input type="checkbox"/> QULIPTA	<input type="checkbox"/> 10mg Tablet	<input type="checkbox"/> Take _____mg by mouth once daily (with or without food)		
	<input type="checkbox"/> 30mg Tablet			
	<input type="checkbox"/> 60mg Tablet			
<input type="checkbox"/> UBRELVY	<input type="checkbox"/> 50mg Tablet	<input type="checkbox"/> Take _____mg by mouth as directed		
	<input type="checkbox"/> 100mg Tablet		<input type="checkbox"/> _____	

### PRESCRIPTION SIGNATURE

Dispense as Written: \_\_\_\_\_ Substitution Permitted: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Blue Sky Specialty Pharmacy and it's representatives to act as my agent in order to initiate and execute the insurance prior authorization process / appeals if necessary, in doing so, to release clinical information via phone / fax to appropriate third party payer