Migraine
Prescription Referral Form

Phone: 843-352-7662 | Fax 833-898-3992 | Backup Fax 843-352-7632 | 1501 Belle Isle Ave #150 Mt. Pleasant SC 29464

blue sky SPECIALTY PHARMACY

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

Prescriber 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 CHART NOTES AND RELEVANT LABS

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 MD

MEDICATION	DOSAGE	SIG	QTY	RFLS
☐ AIMOVIG	☐ 70mg/mL Pen ☐ 140mg/mL PFS	☐ Inject 70mg SC once monthly ☐ Inject 140mg SC once monthly		
☐ AJOVY	☐ 225mg/1.5mL PFS ☐ 225mg/1.5mL Autoinjector	☐ Inject 225mg SC once monthly ☐ Inject 675mg SC every 3 months		
☐ BOTOX	☐ 100 Unit Vial	☐ _____ _____		
☐ EMGALITY	☐ 120mg/mL PFS ☐ 120mg/mL Pen ☐ 100mg/mL PFS	☐ Loading Dose: Inject 240mg SC on day 1 ☐ Maintenance Dose: Inject 120mg SC once monthly ☐ Loading Dose: Inject 300mg SC on day 1 (onset of cluster period) ☐ Maintenance Dose: Inject 300mg SC once monthly (until end of cluster period)		
☐ NURTEC ODT	☐ 75mg Tablet	☐ Take 75mg by mouth as needed (MAX of 1 tablet every 24 hours) ☐ Take 75mg by mouth once every other day		
☐ QULIPTA	☐ 10mg Tablet ☐ 30mg Tablet ☐ 60mg Tablet	☐ Take _____mg by mouth once daily (with or without food)		
☐ UBRELVY	☐ 50mg Tablet ☐ 100mg Tablet	☐ Take _____mg by mouth as directed ☐ _____		

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 payor.

Important Notice: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you have received this communication and you are not the intended recipient, you should not disseminate, distribute, or copy this fax. Please notify sender immediately if you have received in error and then destroy this document immediately.