# Migraine Enrollment Form

CVS specialty®

**Fax Referral To:** 1-855-297-1270 **Phone:** 1-888-280-1190
**Address:** 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927 **NCPDP:** 4026325

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
*Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

### 2 PRESCRIBER INFORMATION

Prescriber's Name: _____ Group or Hospital: _____
State License #: _____ NPI #: _____ DEA #: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

### 3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

### 4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

**Diagnosis (ICD-10):**
☐ G43.9 Migraine, unspecified ☐ Other Code: _____ Description _____

**Patient Clinical Information:**
Allergies: _____ Height: _____in/cm Weight: _____lb/kg

**Nursing:**
Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health
Injection training not necessary. Date training occurred: _____
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

### 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Aimovig | ☐ 70 mg/mL SureClick Autoinjector (pk of 1)<br>☐ 140 mg/mL SureClick Autoinjector (pk of 1) | Inject _____ mg SC once monthly | ☐ 1-month supply<br>☐ 3-month supply<br>☐ Other: _____<br>Refills: _____ |
| ☐ Ajovy | 225 mg/1.5mL prefilled syringe | ☐ 225 mg SC monthly<br>☐ 675 mg SC every 3 months | ☐ 1-month supply<br>☐ 3-month supply<br>Refills: _____ |
| ☐ Emgality | ☐ 120 mg/mL single-dose prefilled pen (carton of 2)<br>☐ 120 mg/mL single-dose prefilled syringe (carton of 2) | Loading Dose: Inject 240 mg SC one time | Quantity: 1 carton<br>Refills: 0 |
| ☐ Emgality | ☐ 120 mg/mL single-dose prefilled pen<br>☐ 120 mg/mL single-dose prefilled syringe | ☐ Maintenance dose: Inject 120 mg subcutaneously monthly<br>☐ Other: _____ | Quantity: _____<br>Refills: _____ |
| ☐ Other: _____ | Other: _____ | Other: _____ | Quantity: _____<br>Refills: _____ |

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
**Prescriber's Signature:** _____**Date:** _____

May Substitute / Product Selection Permitted / Substitution Permissible
**Prescriber's Signature:** _____**Date:** _____

**CA, MA, NC & PR**: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.