

Migraine Enrollment Form



Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

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 auto mated 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
<input type="checkbox"/> Aimovig	<input type="checkbox"/> 70 mg/mL SureClick Autoinjector (pk of 1) <input type="checkbox"/> 140 mg/mL SureClick Autoinjector (pk of 1)	Inject _____ mg SC once monthly	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Ajovy	225 mg/1.5mL prefilled syringe	<input type="checkbox"/> 225 mg SC monthly <input type="checkbox"/> 675 mg SC every 3 months	<input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply Refills: _____
<input type="checkbox"/> Emgality	<input type="checkbox"/> 120 mg/mL single-dose prefilled pen (carton of 2) <input type="checkbox"/> 120 mg/mL single-dose prefilled syringe (carton of 2)	Loading Dose: Inject 240 mg SC one time	Quantity: 1 carton Refills: 0
<input type="checkbox"/> Emgality	<input type="checkbox"/> 120 mg/mL single-dose prefilled pen <input type="checkbox"/> 120 mg/mL single-dose prefilled syringe	<input type="checkbox"/> Maintenance dose: Inject 120 mg subcutaneously monthly <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Other:	Other: _____	Other: _____	Quantity: _____ 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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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