Cosentino's
SPECIALTY CARE

# MIGRAINE SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

v9.3_101018

## 1 PATIENT INFORMATION:

Name: ______
Address: ______
City: ______ State: ____ Zip: ______
Phone: ______ Alt. Phone: ______
Email: ______
DOB: ______ Gender: ❍ M ❍ F Caregiver: ______
Height: ______ Weight: ______ Allergies: ______

## 2 PRESCRIBER INFORMATION:

Name: ______
Address: ______
City: ______ State: ____ Zip: ______
Phone: ______ Fax: ______
NPI: ______ DEA: ______
Tax I.D.: ______
Office Contact: ______ Phone: ______

## 3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: ______ ICD-10: ______

Number of Migraine Attacks:

❑ Per Day: ______ ❑ Per Month: ______

Type of Migraine: ❑ Fully Reversible ❑ Partially Reversible

Aura Symptoms Present? ❑ No ❑ Yes ❑ If yes, list symptoms: ______

Patient also taking Botox? ❑ No ❑ Yes

Please attach any of the following (if applicable):

❑ Angiography ❑ Blood & Urine Chemistry ❑ Eye Examination(s) ❑ X-Ray ❑ Other

| Prior Failed Treatments: | Indicate Drug Name and Length of Treatment: |
|---|---|
| ❑ Botox | ______ |
| ❑ Ergots | ______ |
| ❑ NSAIDS | ______ |
| ❑ Triptans | ______ |
| ❑ Other | ______ |

**If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.**

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## 4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

## 5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

## 6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

## PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: ______ Patient's Date of Birth: ______

| Medication | Dosage & Strength | Direction | QTY | Refills |
|---|---|---|---|---|
| ❑ AIMOVIG™ | ❑ 70mg/ml SureClick® Autoinjector<br>❑ 70mg/ml Prefilled Syringe | ❑ Inject 70mg SC once a month | 1 | |
| | | ❑ Inject 140mg SC once a month *(Inject two 70mg/ml injections consecutively)* | 2 | |
| ❑ AJOVY™ | ❑ 225mg/1.5ml Prefilled Syringe | ❑ Inject 225mg SC once a month | 1 | |
| | | ❑ Inject 675mg SC every 3 months *(Inject three 225mg/1.5ml injections consecutively)* | 3 | |
| ❑ BOTOX® | ❑ 100 Units Single-Dose Vial<br>❑ 200 Units Single-Dose Vial | ❑ Inject 0.1ml (5 Units) intramuscularly per each site divided across 7 head/neck muscles Recommended total dose is 155 units | | |
| ❑ EMGALITY™ | ❑ 120mg/ml Prefilled Pen<br>❑ 120mg/ml Prefilled Syringe | ❑ **Loading Dose:** Inject 240mg SC administered as 2 consecutive injections of 120mg each on Day 1 | 2 | |
| | | ❑ **Maintenance Dose:** Inject 120mg SC once a month starting on Day 29 | 1 | |
| ❑ ______ | ______ | ______ | | |

## PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ______ Date: ______
**Substitution Permitted**

Signature: ______ Date: ______
**Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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