MedPlus SPECIALTY

MIGRAINE SPECIALTY CARE PROGRAM

Phone: **844-378-3784** • Fax: **888-972-7058**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

❶ PATIENT INFORMATION:

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

❷ PRESCRIBER INFORMATION:

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

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

Length of Symptoms: _____ ICD-10: _____
❑ Other diagnosis _____ Number of Migraine Days per month: _____
Headache Days per month: _____ Migraine Hours per day: _____
Patient has been evaluated and does not have medication overuse headache? ❑ No ❑ Yes
MIDAS Score: _____
Aura Symptoms Present? ❑ No ❑ Yes ❑ If yes, list symptoms: _____
Hepatic impairment: ❑ None ❑ Mild ❑ Moderate ❑ Severe
Renal Impairment : ❑ Yes ❑ No CrCl: _____
Patient also taking Botox®? ❑ No ❑ Yes

For Acute Treatment:

Does patient have a contraindication to triptan therapy? ❑ No ❑ Yes
If yes: ❑ CAD ❑ History of stroke ❑ PVD ❑ Uncontrolled hypertension ❑ Other: _____

For Reyvow®: patient agrees to not engage in activities requiring mental alertness for 8 hours after each dose ❑ No ❑ Yes

Was requested medication provided as a sample in MD office? ❑ Yes ❑ No

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

Prior Failed Treatments:	Indicate Drug Name and Length of Treatment:
Preventative:	
❑ ACE-I/ARBs	_____
❑ Antiepileptics	_____
❑ Beta Blockers	_____
❑ CCBs	_____
❑ OnabotulinumtoxinA	_____
❑ TCAs	_____
❑ Other Antidepressants	_____
❑ Supplements	_____
❑ Other	_____
Abortive:	
❑ Ergots	_____
❑ NSAIDs	_____
❑ Injectable Triptans	_____
❑ Nasal Triptans	_____
❑ Oral Triptans	_____
❑ Other	_____

❹ INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support ❍ Na

❺ PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

❻ 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® Single-Dose Autoinjector ❑ 70mg/ml Single-Dose Prefilled Syringe ❑ 140mg/ml SureClick® Single-Dose Autoinjector ❑ 140mg/ml Single-Dose Prefilled Syringe	❑ Inject 70mg SC once a month ❑ Inject 140mg SC once a month	1	
❑ AJOVY®	❑ 225mg/1.5ml Prefilled Syringe ❑ 225mg/1.5ml Prefilled Autoinjector	❑ Inject 225mg SC once a month ❑ Inject 675mg SC every 3 months *(Inject three 225mg/1.5ml injections consecutively)*	1 3	
❑ BOTOX®	❑ 100 Units Single-Dose Vial ❑ 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®	❑ 100mg/ml Single-Dose Prefilled Syringe *(for Cluster Headaches)*	❑ Inject 300mg SC administered as 3 consecutive injections of 100mg each at the onset of the cluster period, then once a month starting on day 29 until the end of the cluster period.	3	
	❑ 120mg/ml Single-Dose Prefilled Pen ❑ 120mg/ml Single-Dose Prefilled Syringe	❑ **Loading Dose:** Inject 240mg SC administered as 2 consecutive injections of 120mg each on Day 1 ❑ **Maintenance Dose:** Inject 120mg SC once a month starting on day 29	1 2	
❑ NURTEC™ ODT	❑ 75mg Orally Disintegrating Tablet Maximum dose in a 24-hour period is 75mg.	**Acute treatment of migraine** ❑ Take one orally disintegrating tablet by mouth as needed. **Preventive treatment of episodic migraine:** ❑ Take 75 mg tablet orally every other day	8	
❑ QULIPTA®	❑ 10mg Tablet ❑ 30mg Tablet ❑ 60mg Tablet	❑ Take one tablet by mouth once daily with or without food **Dose adjustments or avoidance is necessary with concomitant use of certain drugs and patients with severe hepatic or renal impairment.*	30	
❑ REYVOW®	❑ 50mg Tablet ❑ 100mg Tablet ❑ 200mg Tablet	❑ Take_____tablet(s) orally with or without food. Only one dose should be taken in 24 hours. Wait at least 8 hours between dosing and driving or operating machinery.	8	
❑ UBRELVY®	❑ 50mg Tablet ❑ 100mg Tablet	❑ Take orally with or without food. If needed a second dose may be taken at least 2 hours after the initial dose. **Dose adjustments or avoidance is necessary with concomitant use of certain drugs and patients with severe hepatic or renal impairment.*	10 16 30	
❑ _____	_____	_____		

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: _____ Signature: _____ Date: _____

Substitution Permitted **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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