Kohll's RX SPECIALTY CARE

MIGRAINE SPECIALTY CARE PROGRAM

Phone: **877-324-2501** • Fax: **888-972-4110**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

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: _____
Select Diagnosis: ❑ Chronic migraines ❑ Episodic cluster headache
❑ Episodic migraines ❑ Other diagnosis _____
Number of: Migraine Days per month: _____
Headache Days per month: _____ Migraine Hours per day: _____
Type of Migraine: ❑ Fully Reversible ❑ Partially Reversible
Aura Symptoms Present? ❑ No ❑ Yes ❑ If yes, list symptoms: _____
Patient also taking Botox? ❑ No ❑ Yes
Patient has been evaluated and does not have medication overuse headache? ❑ Yes
Please attach any of the following (if applicable):
❑ Angiography ❑ Blood & Urine Chemistry ❑ Eye Examination(s) ❑ X-Ray ❑ Other
Hepatic impairment: ❑ None ❑ Mild ❑ Moderate ❑ Severe
Renal Impairment : ❑ Yes ❑ No CrCl: _____

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:	
❑ Beta Blockers	
❑ Tricyclic Antidepressants	
❑ Anticonvulsants	
❑ Botox	
❑ Other	
Abortive:	
❑ NSAIDS	
❑ Triptans	
❑ Ergots	
❑ Other	

4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist ❍ 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 ❑ 70mg/ml Prefilled Syringe ❑ 140mg/ml SureClick® Autoinjector ❑ 140mg/ml 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 Prefilled Syringe *For Cluster Headaches* ❑ 120mg/ml Prefilled Pen ❑ 120mg/ml Prefilled Syringe	❑ Inject 300mg SC administered as 3 consecutive injections of 100mg each at the onset of the cluster period, then monthly until the end of the cluster period ❑ **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	3 2	
❑ REYVOW™	❑ 50 mg Tablet ❑ 100 mg Tablet	❑ Take_____tablet(s) orally with or without food. Only one dose should be taken in 24 hours. **Avoid driving or operating machinery for at least 8 hours after taking medication.*	8	
❑ UBRELVY™	❑ 50 mg Tablet ❑ 100 mg 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.*	6 8 10 12 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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