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: ____________

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## 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: __________
Patient has been evaluated and does not have medication overuse headache? ❑ No ❑ Yes
Type of Migraine: ❑ Fully Reversible ❑ Partially Reversible
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

**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 (lisinopril, candesartan) | ________ |
| ❑ Antiepileptics (divalproex, gabapentin, topiramate) | ________ |
| ❑ Beta Blockers (propranolol, timolol) | ________ |
| ❑ CCBs (nimodipine, verapamil) | ________ |
| ❑ OnabotulinumtoxinA (Botox®) | ________ |
| ❑ TCAs (amitriptyline, doxepin) | ________ |
| ❑ Other Antidepressants (venlafaxine) | ________ |
| ❑ Supplements (magnesium, riboflavin) | ________ |
| ❑ Other | ________ |
| **Abortive:** | |
| ❑ Ergots (Migranal®) | ________ |
| ❑ NSAIDs (ibuprofen, indomethacin) | ________ |
| ❑ Injectable Triptans (Zembrace®) | ________ |
| ❑ Nasal Triptans (Onzetra Xsail®, Zomig®) | ________ |
| ❑ Oral Triptans (Axert®, Amerge®, Frova®, Imitrex®, Maxalt®, Relpax®) | ________ |
| ❑ Other | ________ |

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## 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<br>❑ 70mg/ml Prefilled Syringe<br>❑ 140mg/ml SureClick® Autoinjector<br>❑ 140mg/ml Prefilled Syringe | ❑ Inject 70mg SC once a month<br>❑ Inject 140mg SC once a month | 1 | |
| ❑ AJOVY® | ❑ 225mg/1.5ml Prefilled Syringe<br>❑ 225mg/1.5ml Prefilled Autoinjector | ❑ Inject 225mg SC once a month | 1 | |
| | | ❑ Inject 675mg SC every 3 months<br>*(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® | ❑ 100mg/ml Prefilled Syringe<br>*For Cluster Headaches* | ❑ 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 | 3 | |
| | ❑ 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 | | |
| ❑ NURTEC™ ODT | ❑ 75mg Orally Disintegrating Tablet | ❑ Take one orally disintegrating tablet by mouth as needed. Maximum dose in a 24-hour period is 75mg. | 8 | |
| ❑ REYVOW® | ❑ 50mg Tablet<br>❑ 100mg Tablet | ❑ Take_______tablet(s) orally with or without food. Only one dose should be taken in 24 hours.<br>**Avoid driving or operating machinery for at least 8 hours after taking medication.* | 8 | |
| ❑ UBRELVY® | ❑ 50mg Tablet<br>❑ 100mg Tablet | ❑ Take orally with or without food. If needed a second dose may be taken at least 2 hours after the initial dose.<br>**Dose adjustments or avoidance is necessary with concomitant use of certain drugs and patients with severe hepatic or renal impairment.* | 6<br>8<br>10<br>12<br>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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