Sunray Specialty Pharmacy

Migraine Enrollment Form

Fax: (215) 471-4001
Phone: (215) 471-4000

PATIENT INFORMATION:

Patient's Name: _____
Address: _____
City, State, Zip Code: _____
Home Phone: _____
Alternate Phone: _____
DOB: _____
Last 4 Digits of SS#: _____
Gender: _____
Language Preference: _____

PRESCRIBER INFORMATION:

Prescriber's Name: _____
DEA: _____
NPI: _____
Address: _____
City, State, Zip Code: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact Person's Phone: _____

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

Prior Authorization Reference #: _____

MEDICAL INFORMATION: (may attach separate sheet if needed)

Diagnosis: Please include diagnosis **and** ICD-10 code

☐ G43.9 Migraine, unspecified
Other:
ICD-10 Code: _____
Description: _____

Additional information:

Therapy: ☐ New ☐ Reauthorization ☐ Restart
Weight: _____ kg/lb Height _____ cm/in
Allergies: _____
Lab Data: _____
Prior Therapies: _____
Concomitant Medications: _____
Injection Training Required: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
Aimovig™	☐ 70mg/mL Autoinjector ☐ 140mg/mL PFS	Inject _____ mg SC once monthly		
Ajovy™	☐ 225mg/1.5mL PFS	☐ Inject 225mg SC once monthly ☐ Inject 675mg SC every 3 months		
Emgality™	☐ 120mg/mL prefilled pen (pack of 2) ☐ 120mg/mL PFS (pack of 2)	☐ Loading dose: Inject 240mg SC once		
Emgality™	☐ 120mg/mL prefilled pen ☐ 120mg/mL PFS	☐ Maintenance dose: Inject 120mg SC once monthly ☐ Other: _____		
OTHER: _____				

Please deliver to: ☐ Patient ☐ Office ☐ Other _____ by this date: _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution Permitted ☐ Dispense as Written

Prescriber's Signature: _____