



Neurology Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs _____ kg _____
 SSN #: XXX-XX-____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ Policy: _____ Group#: _____

Clinical Information

Diagnosis: _____ ICD 10 code: _____
 Number of Migraine days per month: _____ Has patient had prior treatment for this diagnosis? Yes No
 Previous therapies tried and failed: _____
 Reason for discontinuation: _____

Prescription

| Medication | Strength | Directions | Quantity | Refills |
|------------------------------------|--|--|----------|-----------|
| <input type="checkbox"/> Aimovig® | <input type="checkbox"/> 70mg Auto-injector | Inject 1 pen (70mg) subcutaneously once monthly | #1 | |
| | <input type="checkbox"/> 140mg Auto-injector | Inject 1 pen (140mg) subcutaneously once monthly | #1 | |
| <input type="checkbox"/> Ajovy® | <input type="checkbox"/> 225mg/1.5ml Pen | <input type="checkbox"/> Inject 225mg subcutaneously once monthly | #1 | |
| | <input type="checkbox"/> 225mg/1.5ml PFS | <input type="checkbox"/> Inject 3 injections (675mg) subcutaneously once every 3 months | #3 | |
| <input type="checkbox"/> Emgality® | <input type="checkbox"/> 120mg Pen | <input type="checkbox"/> Induction dose: Inject 2 injections (240mg) subcutaneously for one dose | #2 | 0 refills |
| | <input type="checkbox"/> 120mg PFS | <input type="checkbox"/> Maintenance dose: Inject 1 injection (120mg) subcutaneously once monthly | #1 | |
| | <input type="checkbox"/> 100mg PFS | Inject 3 syringes (300mg) subcutaneously once monthly at onset of cluster period | #3 | |

Is patient new to this therapy: YES NO | Ship to: Patient Office Other

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____ This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

fax referral to: **844-812-6227** | phone: **855-265-8008** | **www.vsprx.com**