ABD
Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

PLEASE FAX TO: 207-899-0968
PHONE: 207-899-0939

MIGRAINE ENROLLMENT FORM

PATIENT INFORMATION		
Patient Name:		
Date of Birth:	☐ **Male** ☐ **Female**	
Address:		
Phone:	**Alternate Phone:**	
Height:	**Weight:**	**Allergies:**

DIAGNOSIS	
☐ G43.9 Migraine, unspecified ☐ Other code: _____ Description: _____	**Please also send the following along with this signed form:** • **Chart notes** • **Treatment history and/or current regimen** • **Copy of the patient's prescription insurance card**

DRUG	STRENGTH	DIRECTIONS	QUANTITY/REFILLS
☐ Aimovig®	☐ 70 mg/mL SureClick pen ☐ 140 mg/mL SureClick pen	Inject _____ mg SQ monthly	☐ 1-month supply ☐ 3-month supply ☐ Other: Refills:_____
☐ Ajovy™	☐ 225 mg/1.5 ml prefilled syringe	☐ 225 mg SQ monthly ☐ 675 mg SQ every 3 months	☐ 1-month supply ☐ 3-month supply ☐ Other: Refills:_____
☐ Emgality™	☐ 120 mg/ml prefilled pen ☐ 120 mg/ml prefilled syringe	☐ Loading dose: 240 mg SQ once	1 two-pack, no refills
		☐ Maintenance: inject 120 mg SQ monthly	☐ 1-month supply ☐ 3-month supply ☐ Other: Refills:_____
☐ Other			Quantity: _____ Refills:_____

☐ Patient is ready to start treatment, contact patient for delivery
☐ Ship first order to office for training, subsequent orders to patient
☐ Ship all orders to the office

PRESCRIBER SIGNATURE:		DATE:
PRESCRIBER NAME:	DEA #:	NPI #:
PRACTICE NAME:	PHONE:	FAX:
ADDRESS:	CITY, STATE, ZIP:	OFFICE CONTACT:

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy, ABD will forward the prescription to that pharmacy and the office will be notified.