GIANT EAGLE Specialty Pharmacy

Phone: 1-888-792-1552
Fax: 1-888-216-2510

To ePrescribe send prescription to:
Giant Eagle Pharmacy
20160 Center Ridge Road, Suite 201
Rocky River, OH 44116

MIGRAINE PROPHYLAXIS ENROLLMENT FORM

Today's Date: _____

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up ☐ Store Preference (address): _____ **Rx:** ☐ New ☐ Refill

Patient Information

Date: _____ ☐ Male ☐ Female DOB: _____
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Best Phone Number: _____ Alternate Phone Number: _____
Allergies: _____
Height: _____ Weight: _____ ☐ kgs. or ☐ lbs.
Emergency Contact Name: _____ Emergency Contact Phone #: _____

Insurance Information: Please fax copy of insurance card (front + back)

Prescription

MEDICATION	DIRECTIONS	QTY	REFILLS
☐ **Ajovy® (Fremanezumab-vfrm)**	☐ Inject 225mg SQ once monthly ☐ Inject 675mg SQ once every 3 months	1-month 3-month 3-month	_____
☐ **Aimovig® (Erenumab)**	☐ Inject 70mg SQ once monthly ☐ Inject 140mg SQ once monthly	1-month 3-month	_____
☐ **Emgality® (Galcanezumab)**	**Loading Dose:** ☐ Inject 240mg SQ once as a loading dose **Maintenance Dose:** ☐ Inject 120mg SQ once monthly	1-month 1-month 3-month	NO REFILL _____

Medical Assessment

SELECT THE DIAGNOSIS: ☐ Chronic migraines ☐ Episodic migraines
☐ Other diagnosis: _____ ICD-10 Code(s): _____

CLINICAL INFORMATION:
Is the requested medication prescribed by or in consultation with a neurologist or pain specialist? ☐ **Yes** ☐ **No**
Select if the patient has had **failure** (after at least a 2 month trial) or **Intolerance** to the following:
- ☐ Elavil® (amitriptyline) **OR** Effexor® (venlafaxine)
- ☐ Depakote/Depakote ER® (divalproex sodium) **OR** Topamax® (topiramate)
- ☐ One of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol

Select if the patient has **contraindication** to the following:
- ☐ Elavil® (amitriptyline) **AND** Effexor® (venlafaxine)
- ☐ Depakote/Depakote ER® (divalproex sodium) **AND** Topamax® (topiramate)
- ☐ **ALL** of the following beta blockers: atenolol, propranolol, nadolol, timolol, and metoprolol

Will the requested medication be used in combination with another CGRP inhibitor? ☐ **Yes** ☐ **No**

For chronic migraines, also answer the following:
Has the patient been evaluated for medication overuse headache (MOH)? ☐ **Yes** ☐ **No**
If diagnosed with MOH, will treatment include a plan to taper off the offending medication? ☐ **Yes** ☐ **No**
Does the patient have 15 or more headache days per month, of which at least 8 must be migraine days for at least 3 months? ☐ **Yes** ☐ **No**
Will the requested medication be used in combination with Botox (onabotulinum toxin A)? ☐ **Yes** ☐ **No**

For episodic migraines, also answer the following:
Does the patient have 4 to 14 migraine days per month (but no more than 14 headache days per month)? ☐ **Yes** ☐ **No**

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #: _____ NPI #: _____
Office Address: _____ City: _____ State: _____ ZIP: _____
State License #: _____ DEA #: _____

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.

_____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: _____ **Date:** _____