Neurology Enrollment Form

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 treament for this diagnosis? ❑ Yes ❑ No
Previous therapies tried and failed: ______________________
Reason for discontinuation: ______________________

Prescription

Medication	Strength	Directions	Quantity	Refills
❑ Aimovig®	❑ 70mg Auto-injector	Inject 1 pen (70mg) subcutaneously once monthly	#1	
	❑ 140mg Auto-injector	Inject 1 pen (140mg) subcutaneously once monthly	#1	
❑ Ajovy®	❑ 225mg/1.5ml Pen	❑ Inject 225mg subcutaneously once monthly	#1	
	❑ 225mg/1.5ml PFS	❑ Inject 3 injections (675mg) subcutaneously once every 3 months	#3	
❑ Emgality®	❑ 120mg Pen	❑ Induction dose: Inject 2 injections (240mg) subcutaneously for one dose	#2	0 refills
	❑ 120mg PFS	❑ Maintenance dose: Inject 1 injection (120mg) subcutaneously once monthly	#1	
	❑ 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 | **Need by Date:** ______________

Prescriber Data

Prescriber Name: ______________________
DEA#: ______________ NPI: ______________
Practice Name: ______________________
Contact: ______________ Preferred Method: ❑ Phone ❑ Fax ❑ Email
Address: ______________________
Phone: ______________ Fax: ______________
City: ______________ State: ______________ Zip: ______________
Email: ______________________

My signature below authorizes Restore Rx, Inc. 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 Restore Rx, Inc. 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: **901-388-0407** | phone: **877-388-0507** | **www.restorerx.com**