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MedRX Infusion
www.medrxinfusion.com

Migraine Referral Form

Administer At: ☐ Patien's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name:_____

First Name:_____

Date of Birth:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

2. Prescriber Information

Prescriber Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

NPI# _____ Office Contact:_____

3. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Allergies:_____ Height:_____ Weight:_____

Tried/Failed Meds and Therapies: _____

Diagnosis:_____ ICD 10:_____ #_____ Headache days per month

4. Prescription Information

Medication	Dose	Directions	Dispense	Refill
☐ **Aimovig** (Erenumab-aooe)	☐ 70 mg/ml PF pen ☐ 140 mg/ml PF pen	☐ 70 mg SC once monthly ☐ 140 mg SC once monthly		
☐ **Ajovy** (Fremanezumab-vfrrm)	☐ 225mg/1.5ml PF syringe ☐ 225mg/1.5ml PF pen	☐ 225 mg SC every month ☐ 675 mg SC (225 mg x3) every 3 months	☐ 1-month supply ☐ 3-month supply	
☐ **Botox**	☐ 100 unit vial ☐ 200 unit vial	Administered by provider as directed		
☐ **Emgality** (Galcanezumab-gnlm)	☐ 120mg/ml PF syringe ☐ 120mg/ml PF Pen	☐ Loading Dose: 240 mg SC (120mg/ml x2) ☐ Maintenance Dose: 120 mg SC once monthly		
	☐ 100MG/ML x3 PF syrin	☐ 300 mg at the onset of the cluster headache period and then once monthly until the end of the cluster period		
☐ **Vyepti** (Eptinezumab-jjmr)	☐ 100mg ☐ 300 mg	☐ Infuse 100 mg IV over 30 minutes once every 3 months ☐ Infuse 300 mg IV over 30 minutes once every 3 months	QS of Vyepti 100 mg vials for each dose	
☐ **NURTEC** (Rimegepant)	75mg ODT	☐ Dissolve 1 tablet by mouth for migraines as needed. Can repeat a dose in 24 hours.	1 pack (#8 tablets)	
☐ **UBRELVY** (Ubrogepant)	☐ 50mg ☐ 100mg	☐ Take 1 tablet by mouth for migraines as needed. Can repeat one dose in 2 hours. Max 200mg/24hr ☐ Other: _____	☐ 1 box (#10) ☐ 1 box (#16, only in 100mg)	
☐ **ZEMBRACE® SymTouch®** (Sumatriptan succinate)	3 mg/5mL auto injector	☐ Inject 3mg Subcutaneously ☐ Other: _____	☐ 1 package (4 pens)	
☐ **Other**				

Order will include as needed: Anaphylaxis kit, Diluents, Flushes, Supplies. Skilled Home Health nursing services if administered at home

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting)

I authorize MedRX Infusion Clinical Pharmacy to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature PRESCRIBER SIGNATURE REQUIRED. NO STAMPS._____ Date _____