ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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NEUROLOGY (MIGRAINE) ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 7.15.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

www.commcarepharmacy.com

Plantation, FL
Phone: 888-203-7973
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NCPDP: 1079638
NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:_____ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)
Primary Insurance: Name of Insurer:_____ ID#:_____ BIN#: _____ PCN#:_____ Group#:_____ Phone:_____
Secondary Insurance: Name of Insurer:_____ ID#:_____ BIN#: _____ PCN#:_____ Group#:_____ Phone:_____

Medication Delivery to: (choose one) □Patient's Address □Always to Physician's Office □First fill to Physician's Office, refills to Patient's Address

Injection Training & Education Needs: □Patient has received injection training □Physician's office to provide injection training

Diagnostic Information: Diagnosis (Please provide ICD-10-CM codes) □G43.0 Migraine without aura □G43.1 Migraine with aura
□G43.7 Chronic migraine without aura □Other_____ Date of Diagnosis:_____

Clinical Information:
Does patient have a latex allergy? □Yes □No
Has patient completed trial of oral preventative therapy? □Yes □No
Number of days per month patient experiences migraines:_____

Prior Medications:
_____
_____

Drug Name	Strength	Directions	Quantity	Refills
□Aimovig™	□70mg SureClick Pen	□Inject 70mg SQ every month □Inject 140mg (2 x 70mg) SQ every month	□1-month supply □3-month supply □Other:_____	
□Ajovy™	□225mg Pre-filled Syringe	□Inject 225mg SQ every month □Inject 675mg (3 x 225mg) SQ every 3 months	□1-month supply □3-month supply □Other:_____	
□Botox®	□100unit vial □200unit vial	Inject _____ units IM into the _____ by prescriber	□12-week supply □Other:_____	
□Emgality™	□120mg Pre-filled Pen	□Inject 240mg SQ initially	□2 Pre-filled Pens	
		□Inject 120mg SQ every month	□1-month supply □3-month supply IM = Intramuscularly SQ = Subcutaneously	

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ □DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation):_____ Date:____ □Please select if you would like the patient enrolled in a Manufacturer's Assistance Program

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