



Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice.

## Sage Specialty Pharmacy Migraine Referral Form

WWW.SAGE-SPECIALTYPHARMACY.COM

### Patient Information: Please provide a copy of the patient's insurance card or information

Patient Name:	DOB:	Gender:	Ht:	Wt:
Address:	City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's Name:	ID#:	Group#:	
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List Allergies:				

### Clinical Information

ICD-10 and Diagnosis: _____ Confirmed patient's HAs not due to medication overuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has tried and failed oral prophylactic agents: <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has contraindication to prophylactic agent: <input type="checkbox"/> Yes <input type="checkbox"/> No Please List: _____	Number of headache days per month: _____ Number of migraine headache days per month: _____ Average migraine duration: _____ hr
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### Previous and Current Treatments

Previous Failed Prophylactic Treatments: _____ _____ Previous Failed Acute Treatments: _____ _____	Current Prophylactic Treatment: _____ Current Rescue Treatment: _____
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### Prescription Information

Medication	Strength	Sig	Quantity	Refills
<input type="checkbox"/> Aimovig	<input type="checkbox"/> 70mg/mL Autoinjector <input type="checkbox"/> 140mg/mL Autoinjector	<input type="checkbox"/> Inject 70mg SC every month <input type="checkbox"/> Inject 140mg SC every month	<input type="checkbox"/> 1 month	
<input type="checkbox"/> Ajovy	<input type="checkbox"/> 225mg/1.5mL Autoinjector <input type="checkbox"/> 225mg/1.5mL Prefilled Syringe	<input type="checkbox"/> Inject 225mg SC every month <input type="checkbox"/> Inject 675mg SC every 3 months	<input type="checkbox"/> 1 Box <input type="checkbox"/> 3 Boxes	
<input type="checkbox"/> Botox	<input type="checkbox"/> 100 unit vial <input type="checkbox"/> 200 unit vial	<input type="checkbox"/> To be administered at prescriber's office <input type="checkbox"/>		
<input type="checkbox"/> Emgality	<input type="checkbox"/> 120mg/mL Prefilled Pen <input type="checkbox"/> 120mg/mL Prefilled Syringe <input type="checkbox"/> 100mg/mL Prefilled Syringe	<input type="checkbox"/> Migraine loading: Inject 240mg SC for first month <input type="checkbox"/> Migraine maintenance: Inject 120mg SC every month <input type="checkbox"/> Cluster HA: Inject 300mg at onset of cluster period, then monthly until end of cluster period	<input type="checkbox"/> 1 month <input type="checkbox"/>	
<input type="checkbox"/> Nurtec	<input type="checkbox"/> 75mg Oral Disintegrating Tab	<input type="checkbox"/> Dissolve 1 tablet on the tongue as needed for migraine. Max 1 tab/24hr	<input type="checkbox"/> 8 Tabs	
<input type="checkbox"/> Ubrelvy	<input type="checkbox"/> 50mg Tablet <input type="checkbox"/> 100mg Tablet	<input type="checkbox"/> Take 1 tablet by mouth as needed for migraine. May repeat dose in 2 hours if needed. Max 4 tabs in 24 hours. <input type="checkbox"/> Take 1 tablet by mouth as needed for migraine. May repeat dose in 2 hours. Max 2 tabs in 24 hours.	<input type="checkbox"/> 16 Tabs	
<input type="checkbox"/> Qulipta	<input type="checkbox"/> 30 mg Tablet <input type="checkbox"/> 60 mg Tablet	<input type="checkbox"/> Take 1 tablet daily	<input type="checkbox"/> 30 Tabs	
<input type="checkbox"/>				

### Prescriber Information

Name:	Phone:	Office Contact Name:
Address:	City:	State:
NPI:	DEA:	Fax and/or Email:
Prescriber Signature:	Date:	<input type="checkbox"/> DO NOT SUBSTITUTE

Sage Specialty Pharmacy – Phone: 414-861-7243 Fax: 414-906-0187 Address: 4001 N Oakland Ave Shorewood, WI 53211