WHOLE HEALTH PHARMACY

Neurology Enrollment Form

Fax: 949-340-8008
Phone: 949-305-0788
□ **Urgent Request**
Rep: _____

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***

Patient Name _____
Address_____
Address 2 _____
City, State, Zip _____
Home Phone_____Mobile Phone _____
DOB_____Last Four of SS_____Gender_____
Language Preference _____

PRESCRIBER INFORMATION

Prescriber Name _____
DEA_____
NPI _____
Address_____
City, State, Zip _____
Phone_____Fax_____
Contact Person _____

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization

Diagnosis - Please include diagnosis name with ICD-10 code	Additional information	Therapy □ New □ Reauthorization □ Restart
Diagnosis:_____		

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
□ Aimovig	□ 70mg □ 140mg	□ Inject 70mg SQ once a month □ Inject 140mg SQ once a month	□ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Ajovy	□ 225mg Pen □ 225mg Pre-filled Syringe	□ Inject 225mg SQ once a month	□ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Aptiom	□ 200mg □ 400mg □ 600mg □ 800mg		□ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ __
□ Austedo	□ 9mg □ 12mg	□ Take 1 tablet PO twice daily	□ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Emgality	□ 120mg □ 300mg	□ Inject 240 mg as a single loading dose, followed by 120 mg once monthly □ Inject 300mg SQ once a month	□ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Inbrija	□ 42mg	□ Inhale the contents of two INBRIJA capsules (84 mg) as needed for OFF symptoms, up to 5 times daily	□ 4 capsules □ 12capsules □ 60capsules □ 92capsules	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ __
□ Ingrezza	□ 40mg □ 80mg □ 4 week Initiation pack	□ Take 40mg once daily for one week □ Take 80mg once daily □ Take as directed on pack	□ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Nuplazid	□ 10mg □ 34mg	□ Take 1 tablet PO every day □ Take 1 capsule PO every day	□ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____
□ Ubrelvy	□ 50mg □ 100mg	□ Take 1 tablet po at onset of headache as needed. May repeat in 2 hours if needed. Do not exceed 2 tablets in 24 hours.	□ 21 days □ 30 days	□ 1 □ 2 □ 3 □ 4 □ 5 □ 11 □ _____

Ship to: □ Patient □ Office □ Other_____Date:_____ Need by Date_____

**** Prescriber Authorization:*** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature:_____Date: _____