



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
<input type="checkbox"/> Aimovig	<input type="checkbox"/> 70mg <input type="checkbox"/> 140mg	<input type="checkbox"/> Inject 70mg SQ once a month <input type="checkbox"/> Inject 140mg SQ once a month	<input type="checkbox"/> 30 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Ajovy	<input type="checkbox"/> 225mg Pen <input type="checkbox"/> 225mg Pre-filled Syringe	<input type="checkbox"/> Inject 225mg SQ once a month	<input type="checkbox"/> 30 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Aptiom	<input type="checkbox"/> 200mg <input type="checkbox"/> 400mg <input type="checkbox"/> 600mg <input type="checkbox"/> 800mg		<input type="checkbox"/> 30 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _
<input type="checkbox"/> Austedo	<input type="checkbox"/> 9mg <input type="checkbox"/> 12mg	<input type="checkbox"/> Take 1 tablet PO twice daily	<input type="checkbox"/> 30 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Botox	<input type="checkbox"/> 100 Units SDV <input type="checkbox"/> 200 units SDV			
<input type="checkbox"/> Emgality	<input type="checkbox"/> 120mg <input type="checkbox"/> 300mg	<input type="checkbox"/> Inject 240 mg as a single loading dose, followed by 120 mg once monthly <input type="checkbox"/> Inject 300mg SQ once a month	<input type="checkbox"/> 30 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Inbrija	<input type="checkbox"/> 42mg	<input type="checkbox"/> Inhale the contents of two INBRIJA capsules (84 mg) as needed for OFF symptoms, up to 5 times daily	<input type="checkbox"/> 4 capsules <input type="checkbox"/> 12capsules <input type="checkbox"/> 60capsules <input type="checkbox"/> 92capsules	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _
<input type="checkbox"/> Ingrezza	<input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 4 week Initiation pack	<input type="checkbox"/> Take 40mg once daily for one week <input type="checkbox"/> Take 80mg once daily <input type="checkbox"/> Take as directed on pack	<input type="checkbox"/> 30 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Nuplazid	<input type="checkbox"/> 10mg <input type="checkbox"/> 34mg	<input type="checkbox"/> Take 1 tablet PO every day <input type="checkbox"/> Take 1 capsule PO every day	<input type="checkbox"/> 30 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Nurtec ODT	<input type="checkbox"/> 175mg Tablet	<input type="checkbox"/> Acute treatment of migraine: Take 1 tablet po at onset of headache as needed. Do not exceed 1 tablet in 24 hours. <input type="checkbox"/> Preventative treatment of episodic migraine: Take 1 tablet po every other day		
<input type="checkbox"/> Ubrelvy	<input type="checkbox"/> 50mg <input type="checkbox"/> 100mg	<input type="checkbox"/> 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.	<input type="checkbox"/> 21 days <input type="checkbox"/> 30 days	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 11 <input type="checkbox"/> _____
<input type="checkbox"/> Vyepiti	<input type="checkbox"/> 100mg/ml SDV	<input type="checkbox"/> Recommended dosage is 100 mg as an intravenous infusion over approximately 30 minutes every 3 months. Some patients may benefit from a dosage of 300 mg		

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 lab 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: _____

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