For assistance, contact your pharmacy representative: ________________________ Phone: ________________________ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital **(may not be faxed by patient)**.

Ergomar (ergotamine tartrate)

Prescription/Pharmacy Intake Form

☐Central Pharmacy: ________________________

☐Retail/Community Pharmacy Fax: ________________________ Pharmacy Phone: ________________________

Date Needed: ____________ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: ________________________

PATIENT INFORMATION

Patient name: ________________________ DOB: ____________ ☐Male ☐Female

Address: ________________________

City: ________________________ State: ____________ Zip code: ____________

Phone # (Daytime): ________________________ Phone # (Evening): ________________________

E-mail Address: ________________________ Case Manager: ________________________

Insurance provider **(Please include copy of front and back of card)**: ________________________

ID #: ____________ Policy/Group #: ____________ Phone #: ________________________ ☐Patient is eligible for Medicare

Name of Insured: ________________________ Employer: ________________________

Relationship to Patient: ☐Self ☐Other: ________________________

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is currently on therapy Start date: ____________

Primary diagnosis code and condition (ICD-10): ________________________

Other diagnosis/conditions: ________________________

Date of diagnosis: ____________

☐Other therapies tried & failed (Please list): ________________________

☐Concurrent therapies: ________________________

History of Migraines

Date migraines started: ____________ Number of headache days per month: ____________ Number of headache hours per day: ____________

Check all that apply: ☐Disability due to headache/migraine (eg, work, school) ☐ER visit(s) due to headache/migraine

Allergies: ________________________

Medication	Dose/Directions/Frequency	Quantity	Refills
Ergomar Sublingual Tablets, 2mg (Ergotamine Tartrate 2mg, USP)	☐Place 1 tablet under the tongue at first sign of attack; another tablet can be taken at half-hour intervals thereafter, if necessary. Dosage must not exceed three tablets (6mg) in any 24hour period or five tablets (10 mg) in any one week. ☐Other: ________________________		

PRESCRIBER INFORMATION

Prescriber's name: ________________________ Practice/facility: ________________________

Address: ________________________ City: ____________ State: ________ Zip code: ____________

Office contact: ________________________ Phone: ____________ Fax: ____________

Email: ________________________ Best time to call: ____________ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: ____________ DEA #: ____________ NPI #: ____________ Medicaid UPIN #: ____________

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

________________________ Dispense as written

________________________ Substitution permitted

____________ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

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Drug names are the property of their respective owners.
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