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

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

Pharmacy: _____

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