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

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

Walgreens Specialty Pharmacy

AllianceRx Walgreens Prime, Pittsburgh, PA
Phone: 888-347-3416 Fax: 877-231-8302 ePrescribe: 130 Enterprise Drive Pittsburgh PA 15275

Ergomar (ergotamine tartrate)

Prescription/Pharmacy Intake Form

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

○ 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, if required, to prohibit substitution: _____

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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