

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

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)	<input type="checkbox"/> 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. <input type="checkbox"/> 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

*** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA ***

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. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.