

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ Please fax a copy of front and back of the insurance card(s).	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <input type="checkbox"/> _____ <input type="checkbox"/> _____ ICD-10		Diagnosis Date: _____	
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____	Reason for Discontinuation of Therapy _____ _____ _____	Approximate Start Date _____ _____ _____	Approximate End Date _____ _____ _____
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	Directions	Quantity	Refill
<input type="checkbox"/> Aimovig	70mg/ml Auto-injector	<input type="checkbox"/> Inject 70mg subq monthly	1x 70mg/ml Auto-injector
		<input type="checkbox"/> Inject 140mg subq monthly	2 x 70mg/ml Auto-injectors
<input type="checkbox"/> Ajovy	225mg/1.5 ml PFS	<input type="checkbox"/> Inject 225mg subq monthly	1x 225mg/1.5ml PFS
		<input type="checkbox"/> Inject 675mg subq every 3 months	3 x 225mg/1.5ml PFS
<input type="checkbox"/> Dalfampridine ER <small>generic for Ampyra</small>	10mg tablets	Take one tablet by mouth every 12 hours	60 tablets
<input type="checkbox"/> Dihydroergotamine <small>generic for Migranal</small>	4mg/ml vial	Administer 1 spray in both nostrils as needed for migraine headache, may repeat once in 15 minutes as directed	8 vials
<input type="checkbox"/> Emgality	120mg/ml Auto-injector	<input type="checkbox"/> Initial: Inject 240mg subq as a single loading dose	2 x 120mg/ml Auto-injector
		<input type="checkbox"/> Maintenance: 120mg subq monthly	1 x 120mg/ml Auto-injector
<input type="checkbox"/> Nuedexta	20-10mg capsules	<input type="checkbox"/> Take one capsule by mouth daily for 7 days, then increase to one capsule by mouth twice daily	60 capsules
		<input type="checkbox"/> Take one capsule by mouth twice daily	

Injection Training Provided by: Physican Office CoxHealth at Home Training not needed
 Ship to: Patient Physican Office CoxHealth at Home

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home, and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home

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