Carepoint™
A Pharmacy That Truly Cares

Onzetra Xsail Enrollment Form

P: (855) 237-9112 | F: (855) 237-9113 | www.carepointrx.com

Thank You For Trusting Us With Your Patients Care.

Date Shipment Needed:_____ **Ship To:** ☐ Patient ☐ Physician

PATIENT INFORMATION

Patient Name:_____ Date:_____ SS#:_____
Optional Information To Help Find Coverage

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: (_____) _____ -_____ Alt. Phone: (_____) _____ -_____ DOB:_____

Sex: M ☐ F ☐ Height:_____ Weight:_____ May Pharmacy Contact Patient Directly: Y ☐ N ☐

Insurance Cardholder Name: _____

Rx Insurance:_____ ID #:_____ Group #:_____ RXBIN:_____

Medical Insurance:_____ ID #:_____ Group #:_____ Phone:_____

MEDICAL ASSESSMENT

☐ G43.0 Migraine without aura

☐ G43.1 Migraine with aura

☐ Other: _____

_____

_____

Current Medications: _____

_____

_____

☐ Average number of migraines per month: _____

☐ **Allergies:** _____

Prior Failed Medications

☐ Amerge Length of Treatment _____ to _____ Reason for Discontinuing: _____

☐ Frova Length of Treatment _____ to _____ Reason for Discontinuing: _____

☐ Imitrex Length of Treatment _____ to _____ Reason for Discontinuing: _____

☐ Maxalt Length of Treatment _____ to _____ Reason for Discontinuing: _____

☐ Relpax Length of Treatment _____ to _____ Reason for Discontinuing: _____

☐ Zomig Length of Treatment _____ to _____ Reason for Discontinuing: _____

☐ Other Length of Treatment _____ to _____ Reason for Discontinuing: _____

Symptoms

☐ Photophobia
☐ Phonophobia
☐ Osmophobia
☐ Nausea
☐ Vomiting
☐ Other symptoms: _____

_____

_____

PRESCRIPTION

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
☐ Onzetra Xsail	☐ Administer 11 mg in each nostril at onset of migraine. May repeat after 2 hours if needed. Maximum dose 44 mg/day	1 kit	
☐ Other	☐		

PRESCRIBING PHYSICIAN

Please include a copy of the patients RX insurance card and clinic notes (if available)

Physician Name:_____ Phone: _____ Fax:_____

Clinic: _____ Office Contact:_____ NPI #:_____ DEA #:_____

Address:_____

_____

Physician Signature Date

Pharmacy can only accept original prescription drug orders from patients. Faxed referrals/prescriptions are accepted from physicians office only

By Signing this form and utilizing our services, you are authorizing Carepoint and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.