TREXIMET® (sumatriptan/naproxen) Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

SUM25-01

PATIENT INFORMATION

First Name	Last Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Cell Phone	

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – please include any relevant office visit/lab notes to support this prescription

Patient is: ☐ Naïve / New Start ☐ Therapy Restart ☐ Existing Treatment	Therapy Start Date ____ /____ / ____
Allergies ☐ NKDA ☐ Drug Allergies (please list) : History of hypersensitivity to Non-Steroidal Anti-inflammatory Drugs/Analgesics ☐ Yes ☐ No	
Therapy Requirements: Established clear diagnosis of migraine headache ☐ Yes ☐ No Utilization for prophylactic therapy of migraine headaches ☐ Yes ☐ No Utilization for cluster headaches ☐ Yes ☐ No	*Indication Demographics:* Patient is ≥ 12 years old ☐ Yes ☐ No
Attempted combination therapies: ☐ Triptan + NSAID tried and failed Date ____ /____ / ____ ☐ Other triptan + NSAID trialed and failed Date ____ /____ / ____ (Triptan must be different than first trialed triptan) ☐ Other: _____ Date ____ /____ / ____	Current Medications (please list name and dose): ICD-10 Code ☐ ☐ Other: _____

PRESCRIPTION – *please check all boxes across row*

Medication	Dose (patient weight)	Directions	Quantity/Day Supply	Refills
☐ TREXIMET® (sumatriptan/naproxen)	☐ 85 mg/500 mg sumatriptan / naproxen sodium	Adult: Take 1 tablet of 85/500 mg Max 24-hour dose: Take up to 2 tablets of 85/500 mg; separated by at least 2 hours	☐ 9 for 30 days ☐ 18 for 30 days ☐ 27 for 30 days ☐ _____	☐ 11 ☐ ____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic	Date Shipment Needed By: ____ /____ / ____