ONZETRA® (sumatriptan) Referral Form

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

Zeal Specialty Pharmacy

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

ONZ26-01

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)

Therapies Tried and Failed (please check name and include dates)

☐ Acetaminophen Date ____ /____ / ____
☐ Ibuprofen Date ____ /____ / ____
☐ Naproxen Date ____ /____ / ____
☐ Rizatriptan Date ____ /____ / ____
☐ Frovatriptan Date ____ /____ / ____
☐ Zolmitriptan Date ____ /____ / ____
☐ Other: Date ____ /____ / ____

Current Medications (please list name and dose)
☐ MAO-A inhibitor (isocarboxazid, selegiline, phenelzine)
☐ Ergotamine-containing, ergot-type, or another 5-HT1 medication (dihydroergotamine, buspirone)
☐ Other: _____

ICD-10 Code ☐ G43.909 Acute migraine headache
☐ Other: _____

Indication Demographics:
☐ Migraine headache diagnosis

Reason for therapeutic failure/therapy not tried
☐ Adverse Reactions (stomach upset, liver toxicity, kidney toxicity)
☐ Adherence concerns
☐ Hypersensitivity aspirin, acetaminophen or ibuprofen
☐ On anticoagulation/antiplatelets (clopidogrel, warfarin)
☐ Increased risk of bleeding
☐ Heart conditions
☐ Increased risk of serious cardiovascular thrombotic effects
☐ Other: _____

PRESCRIPTION – *please check all boxes across row*

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **ONZETRA®** (sumatriptan)	11 mg nasal powder	USE 1 NOSEPIECE (11 MG) IN EACH NOSTRIL AT ONSET OF HEADACHE AS NEEDED. MAY REPEAT IN 2 HOURS IF NEEDED. MAX OF 44 MG IN 24 HOURS.	☐ 16 (1 box) ☐ _____	☐ 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: ____ /____ / ____