Nerivio Express

ProCare Rx

Prescription Information and Enrollment Form

Please complete and fax this form to ProCare Rx: 855-818-3781

☐ **Face/Demo Sheet Attached (**in lieu of populating insurance information below)

PATIENT INFORMATION (REQUIRED)

Patient Name: ______________________ DOB: ____________

Phone: ____________ E-mail: ______________________

Address: ______________________ City: ____________ State: ______ Zip: ________

PRESCRIBER INFORMATION (REQUIRED)

Healthcare Provider Name: ______________________ NPI: ______________________

Address: ______________________ Prior Authorization Coordinator: ____________

City: ____________ State: ______ Zip: ________ Phone: ____________ Ext: _____ Fax: ____________

Phone: ____________ Fax: ____________ E-mail: ______________________

PHARMACY PRESCRIPTION (REQUIRED)

Rx: Nerivio Quantity per fill: 1 Refills: ☐ 12 ☐ 24 ☐ Other ______

Directions: Start treatment within 60 minutes of migraine onset. Set a strong, yet comfortable intensity level in the first few minutes and maintain THAT LEVEL for 45 minutes.

Diagnosis : ______________________ ICD-10 code: ____________

Healthcare Provider Signature: ______________________ Date: ____________

ProCare PharmacyCare, LLC is committed to helping your patients receive their prescribed treatment therapy. By signing this form, you certify that you have obtained all necessary consent from the patient to obtain and disclose any information about the patient, including any protected health information (as defined in the HIPAA Privacy Rules, as amended from time to time), from the insurer, including eligibility and other benefit coverage information, for your payment and/or healthcare operation purposes. ProCare PharmacyCare, LLC agrees that it will comply with the applicable requirements to safeguard any protected health information that it obtains on your behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

INSURANCE INFORMATION: Please fill out this section in its entirety or provide a copy of the patients demo (face) sheet.

Prescription Insurance: ______________________

Cardholder Name: ______________________

Rx Group # ____________ Rx ID # ____________

Rx BIN # ____________ Rx PCN # ____________

Primary Medical Insurance: ______________________

Cardholder Name: ______________________

Group # ______________________

Medical Insurance ID # ______________________

Plan Payer ID # ____________ Plan Phone # ____________

ProCare Mail Order Pharmacy

2650 SW 145th Ave
Miramar, FL 33027-6606
Phone: 877-210-1206
Fax: 855-818-3781

Methods of Patient Enrollment

Attach, email or fax patient's insurance information if possible

- Fax form to ProCare Rx: 855-818-3781
- Email form to ProCare Rx: neriviorx@procarerx.com
- E-Prescribe to ProCare/ProMod Rx (Miramar, FL)

NCPDP: 1098121 NPI: 1427160357

☐ **Chart Notes Attached** (Optional)