

Prescription Information and Enrollment Form

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

Face/Demo Sheet Attached Chart Notes Attached

PATIENT INFORMATION (REQUIRED)

Patient Name: _____ DOB: _____

Mobile Phone: _____ E-mail: _____

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

PRESCRIBER INFORMATION (REQUIRED)

Healthcare Provider Name: _____ NPI: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

E-mail: _____ Fax: _____

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.

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.

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