gammaCore

Patient Enrollment Form

Customer Service: (844) 632-9264
Fax completed form to: (877) 427-4186
Email completed form to: gammaCAREdirect@asembia.com

☐ Check here if your patient is enrolled in gammaCore Patient Registry

***Indicates required field**

PRESCRIPTION INFORMATION

*Patient Name (Last, First):

*Date of Birth: Gender: M ☐ F ☐

*Address: (Cannot be a PO Box)

*City *State *Zip

*Cell *Home Phone

*Email *SSN

Emergency contact: Phone #:

Device: **gammaCore**

*Date *Days Supply: **31**

*Quantity: **1** *Refills:

***Sig (Directions):** gammaCore® (non-invasive vagus nerve stimulator) is indicated for the acute treatment of pain associated with episodic cluster headache and migraine in adult patients. Please refer to the gammaCore Instructions for Use for all of the important warnings and precautions before using or prescribing this product.

PROVIDER ATTESTATION

By signing below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that ASPN Pharmacies, LLC (ASPN) reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize ASPN as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow ASPN to email me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

*Prescriber's Signature

Signature is required to process the prescription. Stamped signatures are not permissible.

(Dispense As Written)

*Date of Signature

PRIMARY PRESCRIPTION INSURANCE

(1) Fill in fields with pharmacy insurance information (NOT medical), OR (2) Fax Patient Demographic Information or Patient Insurance Card along with enrollment form.

*Insurance Name: Pharmacy Help Desk Phone #:

Policyholder Name: *Relationship to Patient:

*Member ID: *Group ID:

*Rx BIN: *PCN:

MEDICAL INSURANCE INFORMATION

*Primary Insurance: *Phone:

*Member ID: *Group ID:

Secondary Insurance: Phone:

Member ID: Group ID:

PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

*NPI:

*Prescriber's Primary Specialty: ☐ **Neurology** ☐ **Other**_____

*Prescriber Phone: *Fax:

*Address:

*City: *State: *Zip:

Email:

Tax ID: DEA:

Prescriber Office Contact Information

*Office Contact Name (Last, First):

*Email: *Phone:

CLINICAL INFORMATION

*Diagnosis: ☐ G43.___ - Migraine
☐ G44.011 - Episodic cluster headache, intractable
☐ G44.019 - Episodic cluster headache, not intractable
☐ Other_____

History of, or at risk for, severe allergic reaction to:

electroCore®