



Customer service: (866) 892-0038
Fax Completed form to: (855) 702-3626



PATIENT INFORMATION

*PATIENT NAME (LAST, FIRST):

☐ FEMALE ☐ MALE

*DATE OF BIRTH (MM/DD/YYYY):

*GENDER:

*ADDRESS (CANNOT BE A PO BOX):

*CITY:

*STATE:

*ZIP:

*CELL:

*HOME PHONE:

EMAIL:

ADDITIONAL CONTACT

PHONE

PRESCRIBER INFORMATION

*PRESCRIBER NAME (LAST, FIRST):

NPI:

*PRESCRIBER PHONE:

FAX:

ADDRESS:

*CITY:

*STATE:

*ZIP:

EMAIL:

*OFFICE CONTACT NAME (LAST, FIRST):

EMAIL:

PHONE:

PRESCRIPTION INFORMATION

TRUDHESA 0.75MCG

☐ NDC: 77530-725-04 (4 CT)

☐ NDC: 77530-725-06 (6 CT)

QTY:

USE 1 SPRAY IN EACH NOSTRIL AT ONSET OF MIGRAINE. MAY
REPEAT AFTER 1 HOUR. NOT TO EXCEED 2 DOSES IN 24 HOURS OR
3 IN 7 DAYS.

DAYS SUPPLY: ☐ 15 ☐ 30 ☐ 90

REFILLS:

PRESCRIBER SIGNATURE

*PRESCRIBER'S SIGNATURE

SIGNATURE IS REQUIRED TO PROCESS THE PRESCRIPTION.
STAMPED SIGNATURES ARE NOT PERMISSIBLE.

(DISPENSE AS WRITTEN)

*DATE OF SIGNATURE

CLINICAL INFORMATION

*DIAGNOSIS CODE/ICD-10 CODE:

☐ G43 ☐ G43.0 ☐ G43.1 ☐ G43.9 ☐ OTHER

*PLEASE LIST ANY KNOWN ALLERGIES TO MEDICATION OR OTHER SUBSTANCES:

SUPPORTING CLINICAL INDICATIONS

Number of Headaches per month _____

Previously tried and failed Triptans _____

PRIMARY PRESCRIPTION INSURANCE

INSURANCE NAME:

PHARMACY HELP DESK PHONE #

*POLICYHOLDER:

NAME:

*RELATIONSHIP TO PATIENT

*MEMBER ID:

GROUP ID:

RX BIN:

PCN:

MEDICAL INSURANCE:

E-PRESCRIBE TO:

ASPN Pharmacies, LLC

290 West Mount Pleasant Ave

Building 2, 4th Floor, Suite 4210

Livingston, NJ 07039

NPI: 1538590690