Ergomar® Sublingual Tablets, 2mg
(Ergotamine Tartrate Sublingual Tablets, USP)

Patient Enrollment Form

Customer Service: 1-866-473-0089
Fax completed form to: 1-866-404-1838 | **Visit us:** Ergomar.com

Please see full Prescribing Information, including Boxed Warning at Ergomar.com

PLEASE ATTACH INSURANCE CARD IMAGE.

Patient Information

Patient Name (Last, First):

Date of Birth:	Gender:

Address:

City:	State:	Zip:

Cell Phone:	Home Phone:

Email:

Additional Contact:	Phone:

Prescription Information

Drug: **Ergomar 2mg®**	Date:
Quantity: **20 Sublingual Tablets**	Refills:

Directions:

Additional Information

Provider Attestation

By my signature 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 Asembia Specialty Pharmacy Network 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 (Dispense As Written)

Date of Signature

ERG-P-1053 (05/2020)

Pharmacy Insurance Information

Insurance Name:	Pharmacy Help Desk #:
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: □In Network □Out of Network

Prescriber Information

Prescriber Name (Last, First):

NPI:

Prescriber Phone:	Fax:

Address:

City:	State:	Zip:

Email:

Tax ID:	Medicaid Provider ID:

Prescriber Office Contact Information

Office Contact Name (First, Last):

Email:	Phone:

Additional Information (Required Information)

Please attach any supporting documents.

Diagnosis Code(s):

Product(s) used: