Trudhesa®
(dihydroergotamine mesylate) nasal spray
0.725 mg per spray

aspn Pharmacies

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

QTY: ☐ 4 PODS ☐ 8 PODS

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: ☐ 30 ☐ 90 REFILLS:

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 _____

PRESCRIBER SIGNATURE

*PRESCRIBER'S SIGNATURE:
SIGNATURE IS REQUIRED TO PROCESS THE PRESCRIPTION. STAMPED SIGNATURES ARE NOT PERMISSIBLE.

(DISPENSE AS WRITTEN)

*DATE OF SIGNATURE:

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**