

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

G43.9 - Migraine, unspecified, not intractable _____ - _____ _____ - _____

DIAGNOSIS FACTORS:

Average number of headache days experienced per month over the past 3 months: _____ Average number of migraine days per month over the past 3 months: _____

PRIOR THERAPY:

Antidepressants

- amitriptyline
- fluoxetine
- fluvoxamine
- venlafaxine

Antiepileptics

- carbamazepine
- divalproex
- gabapentin
- lamotrigine
- topiramate
- valproate

CGRP inhibitors

- Aimovig™ (erenumab-aooe)
- Ajovy™ (fremanezumab-vfrm)
- Emgality™ (galcanezumab-gnlm)

Neurotoxins

- Botox™ (onabotulinumtoxinA)

Antihypertensives

- atenolol
- candesartan
- lisinopril
- metoprolol
- nadolol
- nebivolol
- propranolol
- timolol

Ergotamines

- dihydroergotamine (DHE)
- ergotamine

Triptans

- sumatriptan
- rizatriptan
- zolmitriptan
- almotriptan
- naratriptan
- frovatriptan
- eletriptan

NSAIDs

- ibuprofen
- naproxen
- acetaminophen
- aspirin
- ketoprofen
- OTHER: _____

PATIENT INFORMATION:

ALLERGIES: NKDA <input type="checkbox"/>	FIRST DOSE: <input type="checkbox"/> Y <input type="checkbox"/> N
	DATE OF LAST INFUSION:
	NEXT DOSE DUE BY:
HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg	LINE TYPE:
GENDER: <input type="checkbox"/> F <input type="checkbox"/> M	OTHER:

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

1. INSURANCE CARD (Front & Back) 2. PATIENT DEMOGRAPHICS 3. MOST RECENT LABS 4. H & P

PRN & PREMEDICATIONS:

DIPHENHYDRAMINE	<input type="checkbox"/> 25 MG IV in 50 ML NSS OVER 15 MIN	<input type="checkbox"/> 25 MG IVP	<input type="checkbox"/> 25 MG PO
	<input type="checkbox"/> 50 MG IV in 50 ML NSS OVER 15 MIN	<input type="checkbox"/> 50 MG IVP	<input type="checkbox"/> 50 MG PO
LORAZEPAM	<input type="checkbox"/> 0.5 MG IVP <input type="checkbox"/> 0.5 MG PO	<input type="checkbox"/> _____ DOSES PRN	
	<input type="checkbox"/> 1.0 MG IVP <input type="checkbox"/> 1.0 MG PO		
ONDANSETRON	<input type="checkbox"/> 4 MG IV in 50 ML NSS OVER 15 MIN; REPEAT IN 2-3 HOURS AFTER INITIAL DOSE		
	<input type="checkbox"/> 4 MG IVP <input type="checkbox"/> ADDITIONAL DIRECTIONS: _____		
PHENERGAN	<input type="checkbox"/> 25 MG IVP	<input type="checkbox"/> 25 MG IV in 50 ML NSS OVER 30 MINS	
	<input type="checkbox"/> 50 MG IVP	<input type="checkbox"/> 50 MG IV in 50 ML NSS OVER 30 MINS	

MEDICATION SELECTION:



- 100 MG IV EVERY 3 MONTHS
- 300 MG IV EVERY 3 MONTHS

REFILLS: _____



- 70 MG SC ONCE MONTHLY
- 140 MG SC ONCE MONTHLY

REFILLS: _____



- 225 MG SC ONCE MONTHLY
- 675 MG SC ONCE EVERY THREE MONTHS

REFILLS: _____



- LOADING DOSE:** 240 MG SC ONCE
- MAINTENANCE DOSE:** 120 MG SC EVERY MONTH

REFILLS: _____

DHE

- 0.5 MG IV in 50 ML NSS OVER 60 MINS
- 1 MG IV in 50 ML NSS OVER 60 MINS
- 0.5 MG IVP
- 1 MG IVP

REFILLS: _____

VALPROIC ACID

- 500 MG IV in 100 ML NSS OVER 60 MINS
- 1000 MG IV in 100 ML NSS OVER 120 MINS

REFILLS: _____

Mg SULFATE

- 2 G IV in 50 ML NSS OVER 60 MINS

REFILLS: _____

KETORLAC

- 30 MG IVP _____ DOSES PRN

REFILLS: _____

PRESCRIBER INFORMATION:

PHYSICIAN NAME: _____	PHONE: _____
OFFICE CONTACT: _____	FAX: _____
ADDRESS: _____	LICENSE #: _____
CITY, STATE, ZIP: _____	NPI: _____
PHYSICIAN SIGNATURE: _____	DATE: _____