AYSA
THERAPEUTICS INFUSION

MIGRAINE ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: ☐ Migraine (ICD-10 _____) ☐ Other: _____ (ICD-10: _____)

Patient Weight: _____ lbs. Allergies: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

ACUTE MIGRAINE ORDERS

Pre-Medications: ☐ Reglan 10mg IV ☐ Zofran 4mg IV - may repeat x 1 ☐ Zofran 8mg IV ☐ Solu-Medrol 125mg IV
☐ Pepcid 20mg IV ☐ Toradol 30mg IV - *may do 30mg BID, at least 6 hours apart - may receive up to 3 days max*
☐ Benadryl 25mg IV
☐ Other: _____

☐ Magnesium Sulfate 1gm IV in 250mL NS over 1hr *(1 gram max dose)*

☐ DHE 45 ☐ 0.5mg ☐ 1 mg IV in 100mL NS *(max 2mg in 24 hours and/or 6mg/week)*
(must pre-medicate for nausea)

☐ Depacon ☐ 500mg ☐ 750mg IV in 250mL NS over 1 hr

Standing PRN Order: ☐ 1 month ☐ 2 months ☐ 3 months

Max treatment in 7 day period _____

Repeat regimen daily for _____ days

Other Additional: _____

PREVENTION MIGRAINE ORDERS

Vyepti

☐ 100mg IV every 3 months

☐ 300mg IV every 3 months

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____
Phone: _____ Fax: _____ Contact Person: _____