



AYSAs

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: _____

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