PARAGON
INFUSION CENTERS

MIGRAINE
INFUSION ORDERS

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, 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
☐ 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 Paragon Healthcare, 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: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Phone: 877-365-5566 **Fax: 855-889-2946**	**Texas** ☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	**Tennessee** ☐ Knoxville	**Georgia** ☐ Atlanta