MIGRAINE

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

Rx:

Patient Name:

Patient Weight: kg

DOB:

PREVENTION MIGRAINE ORDERS

Vyepti:
(eptinezumab-jjmr)

☐ 100mg IV every 3 months x 1 year
☐ 300 mg IV every 3 months x 1 year
☐ Other: _____

ACUTE MIGRAINE ORDERS

Pre-Medications:
☐ Reglan 10mg IV
☐ Zofran 4mg IVP - may repeat x 1
☐ Zofran 8mg IVP
☐ Pepcid 20mg IVP
☐ Benadryl 25mg IV
☐ Solu-Medrol 125mg IVP
☐ Other:
☐ Toradol 30mg IVP

☐ **Magnesium Sulfate** 1gm IV in 250ml NS over 1hr

Frequency: ☐ One time dose
Repeat regimen daily for _____ days
Max treatment in 7 day period _____

Standing PRN order (optional): ☐ 1 Month ☐ 2 Months ☐ 3 Months

Other: _____

Dx:

ICD-10:

Diagnosis: ☐ Migraine ☐ **Other:**

Physician Signature | **NPI #:** | **DATE:(Valid for 1 year)**

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

PHYSICIAN INFORMATION

Physician Name: | **Clinic:**

Phone: | **Fax:** | **Email:** | **Other:**

Office Mailing Address:

Please include the following

☐ ***Patient demographics** ☐ ***Insurance attached** ☐ ***Diagnosis(supporting)** ☐ ***History & Physical**
☐ ***Lab Results** ☐ ***Clinical progress notes** ☐ ***Medication list** ☐ ***Other Test Results**

For Vyepti:

☐ Has the patient had a documented contraindication/intolerance or failed trial of prophylactic migraine therapy? If yes, which drug(s):
☐ Amitriptyline ☐ Beta blocker ☐ Divalproex ☐ Topiramate ☐ Venlafaxine ☐ Other: _____

☐ Has the patient had a documented contraindication/intolerance or failed trial of a calcitonin gene-related peptide receptor?
If yes, please indicate drug: ☐ Aimovig ☐ Emgality ☐ Ajovy ☐ Other: _____

☐ Chronic Migraine: does the patient have greater than or equal to 15 headache days/ month; OR greater than or equal to 8 migraine days per month? ☐ Yes ☐ No

☐ Episodic Migraine: does the patient have less than 15 headache days per month; OR patient has 4-14 migraine days per month?
☐ Yes ☐ No

☐ Other medical necessity: _____

We can do patient teaching for IV/IM/SQ injections if needed. One time or multiple visits. If insurance allows we can also administer SQ/IM shot.