FAX: 725.228.5220 eMediate INFUSION

MIGRAINE

☐ New Prescription/Referral
☐ Prescription Refill

 # Of Refills:

PATIENT INFORMATION

*Patient Insurance & ID (front and back) are needed

Name:	DOB:	Weight: kg

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	*Email (for the referral update):	
Clinic:	Address:	
NPI:		
Patient's PCP Name:	Phone:	Fax:
Clinic:	Address:	
NPI:		

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

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:**

PRESCRIBER SIGNATURE: x | 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.

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

MIGRAINE

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PATIENT INFORMATION

Name:	DOB:

REQUIRED INFORMATION (please attach)

☐ 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