PARAGON HEALTHCARE

MIGRAINE INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

MEDICAL INFORMATION

Diagnosis: ☐ Migraine

☐ Other: _____

ICD-10 Code: _____

Patient Weight: _____ lbs. (required) Allergies: _____

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

DHE-45 ☐ 0.5mg ☐ 1 mg IV in 100mL NS over 15 minutes
(must pre-medicate for nausea) *max 2mg in 24 hours and/or 6mg/week*

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

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 orders: _____

PREVENTION MIGRAINE ORDERS

Vyepti: ☐ 100mg IV every 3 months x 1 year

☐ 300mg IV every 3 months x 1 year

PROVIDER 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, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

PARAGON HEALTHCARE

COMPREHENSIVE SUPPORT FOR MIGRAINE THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's current medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

For Vyepti:

☐ Has the patient had a documented contraindication/intolerance or failed trial of prophylactic migraine therapy? ☐ Yes ☐ No 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

☐ Include labs and/or test results to support diagnosis (if applicable)

☐ Other medical necessity: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance