PARAGON HEALTHCARE
A Carelon Company

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

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:	ZIP:	
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Chronic Migraine Orders

Drug	Dosing	Refills
Vyepti (eptinezumab)	☐ 100mg IV every 3 months ☐ 300mg IV every 3 months ☐ Other: _____	☐ x 1 year ☐ _____

Acute Migraine Orders

Medications	Frequency	Refills
Pre-medications ☐ Reglan 10mg IV ☐ Toradol 30mg IVP ☐ Zofran 8mg IV ☐ Pepcid 20mg IVP ☐ Zofran 4mg IVP ☐ Benadryl 25mg IV ☐ Solu-Medrol 125mg IVP ☐ Other: _____ **Magnesium Sulfate** ☐ 1 gram IV in 250mL NS over 1hr **DHE-45** ☐ 0.5mg ☐ 1mg 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	☐ One time dose ☐ Repeat regimen daily for _____ days Max treatment in 7 day period _____	☐ None ☐ PRN for: ☐ 1 Month ☐ 2 Months ☐ 3 Months

Other orders: _____

Lab Orders: _____ Lab frequency: _____

Required labs to be drawn by ☐ Paragon Healthcare ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

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.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR MIGRAINE THERAPY

PATIENT INFORMATION

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
  ☐ 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
    If yes, how many? _____
  ☐ Episodic Migraine: does the patient have less than 15 headache days per month; OR patient has 4-14 migraine days per month? ☐ Yes ☐ No
    If yes, how many? _____
☐ Include labs and/or test results to support diagnosis (if applicable)
☐ Other medical necessity: _____