

**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:**  Chronic Migraines  Episodic Migraines  Other: \_\_\_\_\_

**ICD-10 Code:** \_\_\_\_\_

Patient Weight: \_\_\_\_\_ lbs. (required) Allergies: \_\_\_\_\_

**THERAPY ORDER**

**Vyepti**

100mg IV every 3 months

300mg IV every 3 months

**Refill for:**  6 months  1 year  Other: \_\_\_\_\_

Other orders: \_\_\_\_\_

**Lab Orders:** \_\_\_\_\_ **Frequency:**  Every infusion  Other: \_\_\_\_\_

Required labs to be drawn by:  Paragon  Referring Provider

**Anaphylactic Reaction Orders:**

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

**Flush orders:** NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

**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:*



**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
- 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: \_\_\_\_\_

ParagonHealthcare 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**