# MIGRAINE
## Infusion Orders

**PHONE** 515.225.2930 | **FAX** 515.559.2495

### Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

**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

**Premedications**

☐ Reglan 10 mg IV ☐ Zofran 4 mg IVP – may repeat x1 ☐ Zofran 8 mg IVP

☐ Pepcid 20 mg IVP ☐ Benadryl 25 mg IV ☐ Toradol 30 mg IVP

☐ Solu-Medrol 125 mg IVP ☐ Other: _____

☐ **Magnesium sulfate** 1 gm IV in 250 mL NS over 1 hour

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

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

**Frequency**

☐ 1 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:** ☐ 100 mg IV every 3 months x1 year ☐ 300 mg IV every 3 months x1 year

### Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* 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 Hy-Vee Health selecting site of care (if checked, please list site of care): _____

### Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX ☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM

# 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? ☐ Yes ☐ No

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: _____

Hy-Vee Health 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.

HY-VEEHEALTHINFUSION.COM