Comprehensive Support for Migraine Therapy

Infusion Order Form – Page 1 of 2

Clinic Location

☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg. 2, Suite 204, Austin, TX 78758
P: (512) 270-2104
F: (512) 233-2288

Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Supporting clinical notes (H&P) to support primary diagnosis:
  - Include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - Include labs and/or test results to support diagnosis (if applicable)
  - Indication for preventative treatment of migraines in adult patients
- Include signed and completed order (MD/prescriber to complete page 1)

For Vyepti:

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

Orders

NURSING

☑ Nursing care per Harbor Health Nursing Procedures and Harbor Health Adverse Reaction Management Protocol.

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Date: Patient Name: DOB:

Orders, cont.

PRE-MEDICATION ORDERS

☐ Reglan 10mg IV
☐ Pepcid 20mg IVP
☐ Solu-Medrol 125mg IVP
☐ Toradol 30mg IVP
☐ Zofran 4mg IVP - may repeat x 1
☐ Benadryl 25mg IV
☐ Zofran 8mg IVP
☐ Other: _____
Dose: _____Route:_____Frequency:_____

THERAPY

ACUTE MIGRAINE THERAPY

☐ **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 dailey for _____days
Max treatment in 7 day period _____

☐ Patient is required to stay for 30 min. observation
☐ Refills: ☐ Zero ☐ for 12 months ☐ _____
(if not indicated order will expire one year from date signed)

PRE-MEDICATION ORDERS FOR VYEPTI

☐ Acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ Cetirizine (Zyrtec) 10mg PO
☐ Loratadine (Claritin) 10mg PO
☐ Diphenhydramine Benadryl) ☐ 25mg / ☐ 50mg / ☐ PO / ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Hydrocortisone (Solu-Cortef) 100mg IV
☐ Other: _____
Dose: _____Route:_____

MIGRAINE PREVENTION THERAPY

☐ Eptinezumab-jjmr (Vyepti) in 100ml 0.9% sodium chloride. Infuse intravenously (IV) with a 0.2-0.22 micron in-line or add-on filter.
Dose: ☐ 100mg / ☐ 300mg
Frequency: ☐ every 3 months / ☐ 6 months / ☐ 1 year / ☐ Other____
Rate: Infuse over 30 minutes
☑ Patient is required to stay for 30 minute observation

Special Instructions

NOTES:

Provider Name (Print): Provider Signature: Date:

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