



Jupiter Infusion
140 Jupiter Lakes Blvd, Suite A
Jupiter, FL 33458
Office: 561-277-9211

Acute Migraine Order Form

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 561-277-9226

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

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

Diagnosis: Migraine Other: _____ ICD-10 Code: _____

ACUTE MIGRAINE ORDERS

Pre-medications

- | | |
|--|--|
| <input type="checkbox"/> Reglan 10mg IV | <input type="checkbox"/> Zofran 4mg IVP – may repeat x 1 |
| <input type="checkbox"/> Pepcid 20mg IVP | <input type="checkbox"/> Zofran 8mg IVP |
| <input type="checkbox"/> Solu-Medrol 125mg IVP | <input type="checkbox"/> Benadryl 25mg IV |
| <input type="checkbox"/> Toradol 30mg IVP | <input type="checkbox"/> Other: _____ |

Magnesium Sulfate 1gm IV in 250mL NS 1hr

DHE-45 0.5mg **OR** 1mg IV in 100mL NS over 15 minutes

Frequency One time dose Repeat regimen daily for _____ days

Standing PRN order (optional): 1 Month 2 Months 3 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

Robaxin: 1000mg IV every 2 weeks PRN 1500mg IV every 2 weeks PRN. Other: _____

Please provide patient's demographic information, insurance information, medication list, and clinical notes. Jupiter Infusion 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 assist them in enrolling in any available co-pay assistance programs as needed/applicable. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _____ Signature: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____