

Patient Information

Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	

Additional Information Needed

- | | | |
|---|--|---|
| <input type="checkbox"/> Fax front/back of insurance card | <input type="checkbox"/> Fax clinical/progress notes | <input type="checkbox"/> Fax labs |
| <input type="checkbox"/> Fax patient demographics | <input type="checkbox"/> Fax current medication list | <input type="checkbox"/> Fax TB and Hep B results |

Diagnosis and Clinical Information
Diagnosis (ICD-10):

- G43 Migraine
 G43.7 Chronic Migraine without Aura
 G43.71 Chronic Migraine without Aura, Intractable
 G43.8 Other Migraine
 G43.82 Menstrual Migraine, Not Intractable
 G43.9 Migraine, Unspecified
 G43.91 Migraine, Unspecified, Intractable
 Other: Code: _____ Description: _____

Clinical Information:

- New Therapy Induction Therapy Change Therapy Continuation
 Patient Weight: _____ lbs / _____ kg Patient Height: _____ in / _____ cm
 Allergies: _____
 Therapies Tried and Failed: _____

Lab Orders

- CBC CMP
 Other: _____

Lab Orders to be done by

- Oklahoma Infusion Services
 Referring Provider

Prescription Information

- Vyepti Dose: 100mg Frequency: every 3 months
 Dose: 300mg

Pre-Medication Orders

- Tylenol tablet 500-1000mg PO PRN Other: _____

Standing Orders for Adverse Reactions

- | | |
|--|---|
| <input checked="" type="checkbox"/> Stop infusion and initiate NS bolus | <input checked="" type="checkbox"/> Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis |
| <input checked="" type="checkbox"/> Notify supervising physician and ordering provider | <input checked="" type="checkbox"/> Oxygen 2-5L nasal cannula |
| <input checked="" type="checkbox"/> Solu-Cortef 100mg SIVP signs of adverse reaction | <input checked="" type="checkbox"/> Albuterol 2.5mg inhaled PRN for chest tightness |
| <input checked="" type="checkbox"/> Benadryl 25mg SIVP for hives or bronchial inflammation | <input type="checkbox"/> Other: _____ |

Prescriber Information


Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:


Prescriber's Signature: _____


Date: _____

By signing this form, you are authorizing Oklahoma Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.

Please fax form to: 405-726-9849

 **Edmond**
 1701 Renaissance Blvd, Ste 110
 Edmond, OK 73013
Phone: (405) 844-4978

 **Enid**
 825 E Owen K Garriott Rd
 Enid, OK 73701
Phone: (580) 701-2586

 **Tulsa**
 6135 S 90th E Ave
 Tulsa, OK 74133
Phone: (539) 215-5609