

**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  
 Allergies: \_\_\_\_\_  
 Therapies Tried and Failed: \_\_\_\_\_

**Lab Orders**

- 
- CBC
- 
- CMP

**Lab Orders to be done by**

- 
- Oklahoma Infusion Services
- 
- 
- Referring Provider

**Prescription Information**

- |                                 |  |   |
|---------------------------------|--|---|
| <input type="checkbox"/> Vyepti | <input type="checkbox"/> Initial Dose: 100mg | <input type="checkbox"/> Maintenance Dose: 100mg every 3 months |
|                                 |  | <input type="checkbox"/> Maintenance Dose: 200mg every 3 months |
|                                 |  | <input type="checkbox"/> Maintenance Dose: 300mg every 3 months |

**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 back 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