

Migraine Referral Form

Please complete the following and fax with clinical documentation to:
720.279.7461

Referral Process

1. PATIENT INFORMATION

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Other Phone: _____
 Email: _____
 DOB: _____ Social Security #: _____
 Gender: M F Height: _____ Weight: _____

2. PHYSICIAN INFORMATION

Physician's name: _____
 License #: _____ NPI #: _____
 DEA #: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Office Contact: _____
 Phone: _____ Fax: _____

Allergies: _____

3. DIAGNOSIS Year of diagnosis: _____

(G43.____) Migraine _____ Other: _____

Number of migraine days/month: _____

List drugs that have been previously tried but failed: _____

4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION

Anticipated Start Date: _____

Aimovig® (erenumab-aooe) 70 mg/ML SureClick®:

Inject 70 mg OR inject 140 mg Frequency: Subcutaneous once monthly
 Dispense: One 70 mg/ML SureClick® Two 70 mg/ML SureClick® Dispense as written Refills: _____

Ajovy® (fremanezumab-vfrm) 225 mg/1.5 mL solution in a single-dose prefilled autoinjector or 225 mg/1.5 mL solution in a single-dose prefilled syringe

225 mg subcutaneous injection monthly
 675 mg subcutaneous injection every 3 months, administered as 3 consecutive injections of 225 mg each
 Refills: _____

Vyepti® (eptinezumab-ijmr)* 100 mg/mL solution in a single-dose vial for intravenous use:

100mg IV over 30 minutes every 3 months 300mg IV over 30 minutes every 3 months Refills: _____
 Dilute each dose in 100 mls 0.9% Sodium Chloride prior to infusing IV over 30 minutes

*Skilled Nursing Services are required

Access: N/A Peripheral Other: _____

FLUSH ORDERS N/A

PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 ml NS, followed by Heparin 2-5 ml if indicated
 Heparin 10 unit/ml Heparin 100 unit/ml

Port: Flush before, after each infusion, and as needed with 5-20 ml NS, followed by Heparin 100 unit/ml 5 ml.

ANAPHYLAXIS ORDERS

Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1.

For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs.

Other: _____

Additional orders: _____

Additional Instructions: _____

6. PHYSICIAN'S SIGNATURE (required): _____ Date: _____