Migraine Order Form

P: 240.200.4464 F: 240.892.3005

PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: ____ DOB: _______________ Phone: _________________________

MEDICAL INFORMATION

Patient Weight: ______________ lbs./kg. (required) Allergies: ____

Diagnosis	Medication Orders	Refills
☐ Migraine **ICD-10 Code:** ________________	**Pre-medications** ☐ Pepcid 20mg IVP ☐ Solu-Medrol 125mg IVP ☐ Toradol 30mg IVP ☐ Zofran 4mg IVP – may repeat x 1 ☐ Zofran 8mg IVP ☐ Benadryl 25mg IV ☐ Other: _________________________ **Hydration** ☐ 250mL Normal Saline IV ☐ 500mL Normal Saline IV **Frequency** ☐ One time dose ☐ Repeat regimen daily for _______ days ☐ Max treatment in 7-day period: _________ **Standing PRN order (optional):** ☐ 1 Month ☐ 2 Months ☐ 3 Months **Other Orders:** ____ _________________________	☐ Other: ________ ☐ x 1 year
Diagnosis: ______________ **ICD-10 Code:** ________________	**Prevention Migraine Orders** ☐ Vyepti: 100mg IV every 3 months x 1-year ☐ Vyepti: 300mg IV every 3 months x 1 year ☐ Robaxin: 1000mg IV every 2 weeks x 1-year ☐ Robaxin: 1500mg IV every 2 weeks x 1 year ☐ Other: ________________________	☐Other: ________ ☐ x 1 year

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit required documentation for approval. Thank you for the referral.

PROVIDER INFORMATION

Provider Name: _________________________________ Signature: _____________________________ Date: __________________

Provider NPI: ___________________ Phone: _________________ Fax: _________________ Contact Person: __________________

ACTIVEINFUSIONS.COM | IMPORTANT NOTICE: This fax is intended only for the named addressee and contains confidential material. If received in error, please notify the sender and destroy all copies.

ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

☐ Phone Call ☐ Text Message ☐ Email ☐ No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder? ☐ Yes ☐ No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION