Hunt Regional Infusion Center

HUNT REGIONAL INFUSION CLINIC
PHONE: 903−408−5840
FAX: 903−455−8773

MIGRAINE PROTOCOL ORDER

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____
HT: _____ WT: _____ DOB: _____ SEX: _____
Street Address: _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____ Cell: _____
Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Policy #: _____
Secondary Insurance Name: _____ Policy #: _____

PHYSICIAN/FACILITY INFORMATION

Physician's Name: _____ Contact Name: _____ Contact Phone: _____
Street Address: _____ City/State/Zip: _____
DEA #: _____ NPI #: _____ FAX: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD−10 Code plus Description) _____

Date of Diagnosis: _____
Does the patient have venous access? ❑ Yes ❑ No If Yes, what type? _____
If No, does the patient need venous access? ❑ Yes ❑ No If Yes, please specify in the prescription orders.

PRESCRIPTION ORDERS

COMPAZINE 25MG, IV, IF NOT AVAILABLE SUBSTITUTE REGLAN 10 MG, IV, X 3 DAYS
DEHYDROERGOTAMINE O.SMG, IV, IF NOT AVAILABLE SUBSTITUTE IMITREX 6MG, SQ, X 3 DAYS
DEPAKENE SOOMG, IVX 3 DAYS
MAGNESIUM SULFATE lGM, IV X 3 DAYS
SOLUMEDROL 125MG, IV ON DAY 1
TORADOL 30MG, IV ON DAYS 2 AND 3

LEAVE IV ACCESS IN PLACE UNTIL TREATMENT IS COMPLETE (IF PT ISA HARD STICK), CHECK BP PRIOR TO DISCHARGE, NO DRIVING FOR 8 HOURS AFTER TREATMENT

Labs Needed: **URINE PREGNANCY TEST 55 YEARS OR LESS (UNLESS HYSTERECTOMY)**

"Pharmacy law may permit pharmacists to substitute a less expensive FDA−approved generically equivalent medication or biosimilar for a brand−name medication or prescribed biologic unless the practitioner indicates otherwise by writing "brand necessary" or "brand medically necessary" on the prescription."

❑ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT −**

UNLESS THE BOX IS CHECKED ALL PICC LINES, MIDLINES, AND CENTRAL LINES MAY BE FLUSHED WITH *HEPARIN 300unit/3mL*

Physician's Signature _____ Date: _____ Time: _____ AM / PM

Fax completed form to Hunt Regional Infusion Center at (903) 455−8773. PLEASE include copies of ALL patients' current insurance cards to expedite benefit verification. Also forward any lab work, Letter of Medical Necessity and any other supporting documentation supporting the use of Infusion Therapy.