ivira infusions

Migraine Referral Form

Please fax completed referral form to ivira:
(302) 486-3400
Please contact office for questions:
(302) 356-0506

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ G43.9 - Migraine, unspecified, not intractable ☐ _____ - _____ ☐ _____ - _____

DIAGNOSIS FACTORS:

Average number of headache days experienced per month over the past 3 months: _____

Average number of migraine days per month over the past 3 months: _____

PRIOR THERAPY:

Antidepressants
- ☐ amitriptyline
- ☐ fluoxetine
- ☐ fluvoxamine
- ☐ venlafaxine

Antiepileptics
- ☐ carbamazepine
- ☐ divalproex
- ☐ gabapentin
- ☐ lamotrigine
- ☐ topiramate
- ☐ valproate

CGRP inhibitors
- ☐ Aimovig™ (erenumab-aooe)
- ☐ Ajovy™ (fremanezumab-vfrm)
- ☐ Emgality™ (galcanezumab-gnlm)

Neurotoxins
- ☐ Botox™ (onabotulinumtoxinA)

Antihypertensives
- ☐ atenolol
- ☐ candesartan
- ☐ lisinopril
- ☐ metoprolol
- ☐ nadolol
- ☐ nebivolol
- ☐ propranolol
- ☐ timolol

Ergotamines
- ☐ dihydroergotamine (DHE)
- ☐ ergotamine

Triptans
- ☐ sumatriptan
- ☐ rizatriptan
- ☐ zolmitriptan
- ☐ almotriptan
- ☐ naratriptan
- ☐ frovatriptan
- ☐ eletriptan

NSAIDs
- ☐ ibuprofen
- ☐ naproxen
- ☐ acetaminophen
- ☐ aspirin
- ☐ ketoprofen
- ☐ OTHER: _____

PATIENT INFORMATION:

ALLERGIES: NKDA ☐	FIRST DOSE: ☐ Y ☐ N
	DATE OF LAST INFUSION:
	NEXT DOSE DUE BY:
HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg	LINE TYPE:
GENDER: ☐ F ☐ M	OTHER:

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. MOST RECENT LABS ☐ 4. H & P

PRN & PREMEDICATIONS:

DIPHENHYDRAMINE	☐ 25 MG IV in 50 ML NSS OVER 15 MIN ☐ 50 MG IV in 50 ML NSS OVER 15 MIN ☐ 25 MG IVP ☐ 50 MG IVP ☐ 25 MG PO ☐ 50 MG PO
LORAZEPAM	☐ 0.5 MG IVP ☐ 1.0 MG IVP ☐ 0.5 MG PO ☐ 1.0 MG PO ☐ ____ DOSES PRN
ONDANSETRON	☐ 4 MG IV in 50 ML NSS OVER 15 MIN; REPEAT IN 2-3 HOURS AFTER INITIAL DOSE ☐ 4 MG IVP ☐ ADDITIONAL DIRECTIONS: _____
PHENERGAN	☐ 25 MG IVP ☐ 50 MG IVP ☐ 25 MG IV in 50 ML NSS OVER 30 MINS ☐ 50 MG IV in 50 ML NSS OVER 30 MINS

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MEDICATION SELECTION:

vyepti™ (eptinezumab-jjmr)	☐ 100 MG IV EVERY 3 MONTHS ☐ 300 MG IV EVERY 3 MONTHS	REFILLS:_____
aimovig™ (erenumab-aooe) injection 70 mg/mL	☐ 70 MG SC ONCE MONTHLY ☐ 140 MG SC ONCE MONTHLY	REFILLS:_____
AJOVY® (fremanezumab)	☐ 225 MG SC ONCE MONTHLY ☐ 675 MG SC ONCE EVERY THREE MONTHS	REFILLS:_____
Emgality® (galcanezumab-gnlm)	**LOADING DOSE:** ☐ 240 MG SC ONCE **MAINTENANCE DOSE:** ☐ 120 MG SC EVERY MONTH	REFILLS:_____
DHE	☐ 0.5 MG IV in 50 ML NSS OVER 60 MINS ☐ 0.5 MG IVP ☐ 1 MG IV in 50 ML NSS OVER 60 MINS ☐ 1 MG IVP	REFILLS:_____
VALPROIC ACID	☐ 500 MG IV in 100 ML NSS OVER 60 MINS ☐ 1000 MG IV in 100 ML NSS OVER 120 MINS	REFILLS:_____
Mg SULFATE	☐ 2 G IV in 50 ML NSS OVER 60 MINS	REFILLS:_____
KETORLAC	☐ 30 MG IVP _____ DOSES PRN	REFILLS:_____

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE:

Clear All

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