Agile Infusion Services LLC
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# MIGRAINE ABORTIVE TREATMENT ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

*Patient's height in feet and inches* _____ *Patient's weight in pounds*_____

■ **Diagnosis** *Please write in the patients specific diagnosis and ICD-10 code to the highest possible character.*
☐ G43._____ _____

■ **Note Regarding Insurance Coverage**
This treatment may not be covered by insurance, in which case the patient would be responsible for the charges. Please discuss this possibility with your patient before submitting this order form.

■ **Intravenous Medication Order** *Select all desired components.*

Antiemetic:
☐ Ondansetron ____mg

NSAID:
☐ Ketorolac ____mg

Steroid:
☐ Methylprednisolone ____mg ☐ Solu-Cortef ____mg ☐ Dexamethosone ____mg

Other Medications:
☐ Magnesium sulfate ____mg ☐ Valproate ____mg ☐ Caffeine citrate 60mg

■ **IV Fluids in which the Migraine Abortive Treatment Order shall be administered:**

☐ NS 0.9% NaCl _____ml over _____minutes ☐ 5% Dextrose _____ml over _____minutes

■ **Frequency**

☐ One time ☐ As needed, up to ____ treatments (valid for 1 year) ☐ Other: _____

■ **Ordering Provider Authorization**

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

**Documentation to Include:**
- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

**FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.**