

Please fax form to: 281-406-1047
or email to referrals@curbsideinfusion.com

Patient Information

Patient Name:	DOB:	Phone:	Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Patient Address:	Email:	Insurance:	

Additional Information Needed

- | | | |
|---|--|---|
| <input type="checkbox"/> Fax front/back of insurance card | <input type="checkbox"/> Fax clinical/progress notes | <input type="checkbox"/> Fax labs |
| <input type="checkbox"/> Fax patient demographics | <input type="checkbox"/> Fax current medication list | <input type="checkbox"/> Fax TB and Hep B results |

Diagnosis and Clinical Information

Diagnosis (ICD-10):

- G43 Migraine
- G43.7 Chronic Migraine without Aura
- G43.71 Chronic Migraine without Aura, Intractable
- G43.8 Other Migraine
- G43.82 Menstrual Migraine, Not Intractable
- G43.9 Migraine, Unspecified
- G43.91 Migraine, Unspecified, Intractable
- Other: Code: _____ Description: _____

Clinical Information:

- New Therapy Induction Therapy Change Therapy Continuation
- Patient Weight: _____ lbs / _____ kg Patient Height: _____ in / _____ cm
- Allergies: _____
- Therapies Tried and Failed: _____

Lab Orders

- CBC CMP
- Other: _____

Lab Orders to be done by

- Curbside Infusion Services
- Referring Provider

Prescription Information

- | | | |
|---------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Vyepti | <input type="checkbox"/> Dose: 100mg | <input type="checkbox"/> Frequency: every 3 months |
| | <input type="checkbox"/> Dose: 300mg | |

Pre-Medication Orders

- Tylenol tablet 500-1000mg PO PRN
- Other: _____

Standing Orders for Adverse Reactions

- | | |
|--|---|
| <input checked="" type="checkbox"/> Stop infusion and initiate NS bolus | <input checked="" type="checkbox"/> Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis |
| <input checked="" type="checkbox"/> Notify supervising physician and ordering provider | <input checked="" type="checkbox"/> Oxygen 2-5L nasal cannula |
| <input checked="" type="checkbox"/> Solu-Cortef 100mg SIVP signs of adverse reaction | <input checked="" type="checkbox"/> Albuterol 2.5mg inhaled PRN for chest tightness |
| <input checked="" type="checkbox"/> Benadryl 25mg SIVP for hives or bronchial inflammation | <input type="checkbox"/> Other: _____ |

Prescriber Information

Prescriber Name:		Office Contact Name:	
NPI #:	DEA #:	Contact Phone:	Contact Fax:

Prescriber's Signature:

Date:

By signing this form, you are authorizing Curbside Infusion Venture, LLC dba Curbside Infusion Services and its employees to act as your designated agent to interact with medical and prescription insurance companies for prior authorization and specialty pharmacy approval to render infusion services.