Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

MIGRAINE TREATMENT MEDICATION ORDER

This treatment may not be covered by insurance, in which case the patient would be responsible for the charges.

Patient's Name (Last, First, Middle) ____ **DOB:** ______________

■ Diagnosis

Please write in the patient's diagnosis and most specific ICD-10 code.

☐ G43._____ ____

■ Medication Order – select components

Antiemetics:

☐ Prochlorperazine 5mg
☐ Metoclopramide 10mg

NSAID:

☐ Ketorolac 20mg

Steroids:

☐ Methylprednisolone 125mg
☐ Hydrocortisone sodium succinate 100mg

Other Medications:

☐ Magnesium sulfate ____grams
☐ Caffeine citrate 60mg
☐ Valproate 500mg

■ Normal Saline

☐ 250ml over 30 minutes
☐ 500ml over 30 minutes
☐ 1000ml over 60 minutes

■ Frequency

☐ One time
☐ As needed, up to ______ treatments
☐ Other: ________________________

■ Ordering Provider Authorization

Provider's Signature: ____________________________ Name: ____________________ Date: ___________________

Address: ____

Phone: ________________ Fax: ___________________ NPI #: _________________ License: ________________

STANDARD 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.
- Patients should be advised that this treatment may not be fully covered by their insurance.

Fax this order and supporting documentation to (732) 329-2322.