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 all desired components

Antiemetic:
☐ Ondansetron _____mg

NSAID:
☐ Ketorolac _____mg

Steroids:
☐ Methylprednisolone _____mg ☐ Solu-Cortef _____mg ☐ Dexamethasone _____mg

Other Medications:
☐ Magnesium sulfate 1,000mg ☐ Valproate _____mg ☐ Caffeine citrate 60mg

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

☐ 0.9% Sodium Chloride _____ml over _____hours ☐ 5% Dextrose _____ml over _____hours

■ Frequency

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

■ Ordering Provider Authorization

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

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

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.