Migraine Order

Phone: (877)-246-9104
Fax: (800) 783-9146
www.biotekrx.com

PATIENT INFORMATION			PRESCRIBER INFORMATION	
Patient Name:			Prescriber Name:	
Address:			State License:	NPI#
City, State, Zip:			DEA:	Phone:
Phone:	2nd Phone:		Address:	Fax:
DOB:	Gender: ☐ Male ☐ Female		City, State, Zip:	
Weight:	Ht:	Date:	Contact Person:	
ICD-10 code:	Diagnosis:		Phone:	
Allergies:				

PREMEDICATION		
☐ Solu-Medrol 125 mg IVP		
☐ Zofran 4 mg SIVP	☐ Zofran 8 mg SIVP	☐ Phenergan 25 mg IM
☐ Toradol 30 mg IVP	☐ Pepcid 20 mg IV	☐ Benadryl 25 mg IV
☐ Toradol 60 mg IVP	☐ Tylenol 325 mg PO	☐ Benadryl 25-50 mg PO

MEDICATION	
☐ Depacon IV 500 mg IV x 1	☐ Depacon IV 1000 mg IV x 1
☐ IV Fluids ______________	☐ IV Fluids ________________
☐ Mag Sulfate IV 1 gm IV	

SIGNATURE

X ____ Date: ______________________

(Product Substitution Permitted)

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