Dihydroergotamine (DHE) IV

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Migraine without aura (G43.001-G43.019), ICD10 _____

☐ Migraine with aura (G43.101-G43.119), ICD10 _____

☐ Chronic migraine without aura (G43.701-G43.719), ICD10 _____

☐ Other migraine (G43.801-G43.839), ICD10 _____

☐ Migraine, unspecified (G43.901-G43.919), ICD10 _____

☐ Other: _____, ICD10 _____

INFUSION ORDERS

** Infusion center to call patient 24-48 hours prior to scheduled infusion date to confirm serotonin 5-HT1A receptor antagonists and ergot alkaloids are stopped within 24 hours of DHE treatment. **

Dihydroergotamine (DHE) Infusion Orders:

- Infuse 0.9% Sodium Chloride 500 mL IV over 31-60 minutes.
- Administer Metoclopramide 10 mg in 0.9% Sodium Chloride 10 mL SIVP over 2 minutes as premed to DHE. May repeat every hour as needed.
  - ☐ May add to 0.9% Sodium Chloride 500 mL bag and infuse IV over 31-60 minutes.
- Infuse DHE 0.5 mg in 0.9% Sodium Chloride 50 mL IV over 15 minutes as test dose.
- If patient tolerates test dose after 30 minutes, may infuse second dose of DHE 0.5 mg in 0.9% Sodium Chloride 50 mL IV over 15 minutes.
- If no resolution of headache after 1 hour, may infuse an additional dose of DHE 1 mg in 0.9% Sodium Chloride 50 mL IV over 15 minutes, for a ***maximum dose of DHE 2mg in a 24-hour period***.

☐ May repeat above DHE Infusion Orders on following days, if necessary, for a ***maximum dose of DHE 6mg per week*** x _____ weeks.

PRN meds:

☐ Diphenhydramine 25 mg in 0.9% Sodium Chloride 10 mL SIVP prn. May repeat x 1.

☐ Ondansetron 4 mg – 8 mg IVP

☐ Ketorolac 15 mg - 30 mg IVP or IM

☐ Dexamethasone 4 mg – 8 mg IVP or IM

☐ Methylprednisolone 125 mg IVP or IM

☐ Other (no controlled substances): _____

Is patient currently receiving therapy above from another facility? ☐ **NO** ☐ **YES**

If yes, Facility Name: _____ Date of last treatment: _____ Date of next treatment: _____

OTHER ORDERS

LAB ORDERS: Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____ ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

ADDITIONAL ORDERS: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.