Medication Management Plan

Date: [Insert Date]

Patient Name: [Insert Patient's Name]

Patient ID: [Insert Patient ID]

Healthcare Provider: [Insert Provider Name]

Diagnosis

Chronic Migraine - [Insert Specific Diagnosis Code]

Medication List

- **Preventive Medications:**
  - [Insert Medication Name] - [Dosage] - [Frequency]
  - [Insert Medication Name] - [Dosage] - [Frequency]
- **Acute Medications:**
  - [Insert Medication Name] - [Dosage] - [Frequency]
  - [Insert Medication Name] - [Dosage] - [Frequency]

Treatment Objectives

1. Reduce the frequency of migraine attacks.

2. Alleviate the severity of symptoms when they occur.

Follow-Up

Please schedule a follow-up appointment in [Insert Time Frame] to assess the effectiveness of the current medication regimen.

Signature: [Insert Provider Signature]