VYEPTI
(eptinezumab-jjmr)

FAX to +1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- History & Physical

- # of Headache Days in Last Month:_____
- # of Migraine Days in Last Month:_____

PRIMARY DIAGNOSIS

☐ G43.009 Migraine w/o aura, not intractable, w/o status migrainosus
☐ G43.709 Chronic migraine w/o aura, not intractable, w/o status migrainosus
☐ G43.711 Chronic migraine w/o aura, intractable, with status migrainosus
☐ G43.719 Chronic migraine w/o aura, intractable, w/o status migrainosus
☐ Other: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Vyepti
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Vyepti 100mg IV every 3 months
☐ Vyepti 300mg IV every 3 months
☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialists.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialists.org for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date