LIFE SPECIALTY SOLUTIONS

VYEPTI
(eptinezumab-jjmr)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Med List 5. Most Recent Labs 6.Tried/Failed Therapies

7. # of Headache Days in Last Month: _____ 8. # 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 _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

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?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

☑ Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE