



Vyepti Referral Form

Phone: (877) 246-9104
Fax: (800) 783-9146

WWW.Biotekrx.com

PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name: _____		Prescriber Name: _____	
Address: _____		NPI #: _____ DEA: _____	
City, State, Zip: _____		Address: _____	
Phone: _____ 2 nd Phone: _____		Phone: _____ Fax: _____	
DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Contact Person: _____ Phone: _____	

INSURANCE INFORMATION - OR - Send a copy of the patient's prescription / insurance cards (front & back)			
Primary Insurance: _____		RX Card (PBM): _____	
City, State, Zip: _____		BIN: _____ PCN: _____	
Member ID #: _____ Phone: _____		City, State, Zip: _____	
Plan #: _____ Group #: _____		Plan #: _____ Group #: _____	

DIAGNOSIS / CLINICAL INFORMATION	
<input type="checkbox"/> G43.7 Chronic Migraine with Aura	Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart
<input type="checkbox"/> G43.70 Chronic Migraine with Aura, no Intractable	Date of last infusion with Vyepti: _____
<input type="checkbox"/> G43.71 Chronic Migraine with Aura, Intractable	Next dose due: _____
<input type="checkbox"/> Other – ICD-10: _____ Specify: _____	
Date of diagnosis: _____	
Average number of migraine days in a month over the past 3 months: _____	
List of previous migraine medication taken: _____	
Patient Weight: _____ lbs.	Height: _____ feet and inches
Allergies: _____	
Comorbidities: _____	

PRESCRIPTION / ADMINISTRATION			
<input type="checkbox"/> Vyepti	<input type="checkbox"/> 100 mg dose (1-100mg vial)	<input type="checkbox"/> 1 vial (100mg)	Refills: _____
	<input type="checkbox"/> 300 mg dose (3-100mg vials)	<input type="checkbox"/> 3 vials (300 mg)	Refills: _____

Administer the diluted Vyepti solution by IV with a 0.2 or 0.22 µm in-line or add-on sterile filter. Infuse over approximately 30 minutes. Flush the line with 20 mL or 0.9% Sodium Chloride Injection, USP. Repeat dose every 3 months.

DOCUMENTATION REQUIRED
<input type="checkbox"/> Current Office Notes, including therapies tried and outcomes
<input type="checkbox"/> Current Medication List
<input type="checkbox"/> History and physical
<input type="checkbox"/> Lab Results
<input type="checkbox"/> Insurance Card Information (front and back)
<input type="checkbox"/> Demographic Sheet

PHYSICIAN'S SIGNATURE
X _____ Date: _____

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form to: (800) 783-9146 - Thank you for using BioTek reMEDys®