

Vyepti Referral Form

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

WWW.Biotekrx.com

DATIENT INFOR	MATION		DDESCRIBER IN	JEOPMATION	
PATIENT INFORMATION Patient Name:			PRESCRIBER INFORMATION Drescriber Name:		
Patient Name:			Prescriber Name:		
Address:					
City, State, Zip:					
				Fax:	
DOB:	Gender:	☐ Male ☐ 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 / CL	INICAL INFORMATIO	N			
			Therapy: ☐ New	☐ Reauthorization ☐ Restart	
☐ G43.70 Chronic Migraine with Aura, no Intractable			Date of last infusion with Vyepti:		
☐ G43.71 Chronic Migraine with Aura, Intractable			Next dose due:		
□ 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:	Ibs.	Height:	feet and inches		
Allergies:					
Comorbidities:					
PRESCRIPTION / ADMINISTRATION					
□ Vyepti	☐ 100 mg dose (1-100m	ng vial)	0mg) Refills:		
, ,	☐ 300 mg dose (3-100m		00 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.					
PHYSICIAN'S SIGNATURE					
			-		
X			Date:		

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