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: _____ 2nd Phone: _____	Phone: _____ 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 / CLINICAL INFORMATION

☐ G43.7 Chronic Migraine with Aura	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: _____ lbs.	Height: _____ feet and inches

Allergies:

Comorbidities:

PRESCRIPTION / ADMINISTRATION

☐ Vyepti	☐ 100 mg dose (1-100mg vial) ☐ 300 mg dose (3-100mg vials)	☐ 1 vial (100mg) ☐ 3 vials (300 mg)	Refills: _____ 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: _____

Fax completed form to: (888) 963-8103 - Thank you for using BioTek reMEDys®