

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	BIN: _____ PCN: _____

CLINICAL INFORMATION

G43.711 Chronic migraine without aura, intractable, with status migrainosus
 G43.111 Migraine with aura, intractable with status migrainosus
 G43.119 Migraine with aura, intractable without status migrainosus
 Other ICD-10: _____
 Date of Diagnosis: _____ Average number of migraine days over the last 3 months: _____
 Previous Migraine Medications: _____
 Obtain the following labs at prior to start of treatment at _____ frequency CBC CMP CRP ESR LFTs X-Ray Other: _____

DRUG ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose	Qty/Refills
<input type="checkbox"/> Vyepti (eptinezumab-jjmr)	<input type="checkbox"/> 100 mg dose (1-100mg vial) <input type="checkbox"/> 300 mg dose (3-100mg vial) <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 vial (100mg) Refills: _____ <input type="checkbox"/> 3 vials (300mg) Refills: _____ <input type="checkbox"/> Other: _____ 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.
 Other: _____

Pre- Medication	Route	Dose
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> PO	<input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)	<input type="checkbox"/> IV	<input type="checkbox"/> 60mg <input type="checkbox"/> 100 mg <input type="checkbox"/> _____mg
<input type="checkbox"/> Diphenhydramine (Benadryl)	<input type="checkbox"/> IV <input type="checkbox"/> PO	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
Other: _____	_____	_____

ANAPHYLACTIC REACTION (AR):

EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary
 EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary
 Diphenhydramine 50mg (1mL) - Give 50 mg slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary
 Hydrocortisone 100mg - Give 100 mg IVP -or- IM if no IV access
 Sodium Chloride 0.9% 500 mL infuse IV at a rate of 30 mL/hr

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VYEPTI®

Please Fax Completed Form To: 800-783-9146
Please Send a Copy of The Patient's Insurance Cards (Front & Back)

<input type="checkbox"/> Other: _____
SIGNATURE
<div style="display: flex; justify-content: space-between;"> <div style="text-align: center;"> X _____ Prescriber Signature </div> <div style="text-align: center;"> Date: _____ </div> </div>

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