BioTek reMEDys®

VYEPTI®

Please Fax Completed Form To: **800-783-9146**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State License: _____

NPI #: _____ Tax ID: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Office Contact: _____ Phone: _____

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

Primary Insurance: _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____

Plan #: _____

Group #: _____

RX Card (PBM): _____

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
☐ Vyepti (eptinezumab-jjmr)	☐ 100 mg dose (1-100mg vial) ☐ 300 mg dose (3-100mg vial) ☐ Other: _____	☐ 1 vial (100mg) Refills: _____ ☐ 3 vials (300mg) Refills: _____ ☐ 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
☐ Acetaminophen	☐ PO	☐ 500mg ☐ 650mg ☐ 1000mg
☐ Methylprednisolone (Solu-Medrol)	☐ IV	☐ 60mg ☐ 100 mg ☐ _____mg
☐ Diphenhydramine (Benadryl)	☐ IV ☐ PO	☐ 25mg ☐ 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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☐ Other: _____

SIGNATURE

X_____ Date: _____

Prescriber Signature