Vyepti (eptinezumab-jjmr)

Order Form
Rev. 1/10/2023

Infusion ASSOCIATES
Phone: (833) 394-0600
Fax: (833) 996-4888

PATIENT INFORMATION **Referral Status:** ○ New Referral ○ Updated Order ○ Order Renewal

Date: Patient Name: DOB:

Allergies: Weight (kg): Height:

ICD-10 Code(s) & Description *(required)*:

☐ *(required)* The patient's demographics, insurance, lab results, meds and recent visit notes were sent to IA.

The patient has an existing prior authorization: ○ Yes *(please fax IA a copy)* ○ No *(IA will process for you)*

PRESCRIBING OFFICE

Contact Name: Contact Phone Number:

Ordering Provider: Provider NPI:

Practice Name: Phone: Fax:

CLINICAL HISTORY

Number of migraines the patient experiences per month: _____

In the past year, what medications for the above diagnosis has the patient tried and failed?

☐ N/A continuation of treatment

Drug & Dose	Dates of Use	Drug & Dose	Dates of Use

LAB ORDERS

Collect: ☐ CMP ☐ CBC w/o Diff ☐ BMP ☐ _____

Lab Frequency: ○ EVERY infusion ○ Every OTHER infusion ○ _____

THERAPY ADMINISTRATION

Vyepti (eptinezumab-jjmr) IV:

Dose: ○ 100 mg ○ 300 mg

Frequency: ○ q 3 months ○ _____

RX Expiration Date: _____

Additional Notes from Referring Office:

Provider Name (Print) **Provider Signature** **Date**